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The Journal of the Australian Branches of the British Medical Association

VOL. II.—6TH YEAR—No. 3. SYDNEY: SATURDAY, JULY 19, 1919. PRICE 6D.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. II.—6TH YEAR. SYDNEY: SATURDAY, JULY 19, 1919. No. 3.

An Address.[1]

By J. C. Verco, Kt., M.D., F.R.C.S.,
President of the South Australian Branch of the British Medical Association.

Exactly fifty years ago, in June, 1869, I was preparing for the matriculation examination of the London University as the portal to the medical profession from the active practice of which I have recently retired.

It is interesting to look back and note the progress made during the past half century in the science and art of medicine, not intesting only, but instructive, gratifying and inspiring. Nor is the retrospect more full of pleasure than is the prospect of hope.

What gives the review its special feature is the element of personal experience, the gradual evolution of one's own knowledge as the passing years have revealed steady, though often startling, discoveries, each one imparting a sense of greater certainty and growing power.

May I transport you for a while to those far distant times?

The difficulty is to choose, from the wealth of material afforded, what will prove of most interest and advantage: for as I stroll back through the fields of memory, the startled novelties fly up on either hand and, gathering in a growing flock, hover around and call their mates, who rise on instant wing.

Did I term them novelties? They are no novelties to you, but common every-day experiences. Many of you, aye, most of you, can hardly imagine a time when these things were not, or conceive how the profession could possibly have done without them. Shall I picture first the little medical world in South Australia as regards its external affairs and note its ancient poverty compared with its wealth of conveniences to-day.

Telephones.—There was not a telephone in the State. If a patient wanted the doctor, a messenger had to come for him, though miles away. Maybe messages were therefore fewer. If a doctor wished to have another in consultation, he must call at his house to see him, perhaps to find him out, and have to call again, or if it were an urgent case, drive to another doctor's house with the same result. It seems to-day incredible and impossible. I recall the first professional telephone, a private one between the houses of Dr. Gardner and Dr. Jay. The latter played a piano in his home in North Adelaide while I listened with a pleased surprise at the other end in Angas Street. For very great distances, of course, the telegraph was available.

Motor Cars.—There was not a motor car in the world. Many of the leading doctors drove about in "pill boxes," little hooded gigs in which they sat with their coachman. Then came more pretentious "Abbott" or light American spider buggies. Next appeared open victorias, closed broughams and hansom cabs. Last arrived the motor cars, which have gradually but completely displaced all other competitors. Dr. Verco's brougham was, I believe, the last horse-drawn vehicle in the medical profession of the city or suburbs, and even his conservatism had to succumb.

How did we manage our long distance journeys then? What can now be done in a day then took nearly a week. And yet we did our work! Yes! but not so much was done; we were content with less visiting and so were our patients, and thus it seems ever to be. Machines whose work is more rapid, do not reduce the hours of labour; they simply augment the amount of finished work demanded, as we see, for instance, in the sewing machine. And this change in transport has entailed a corresponding change in professional costume. In olden times we almost all appeared in black silk top-hats and long black frock coats and, shall I say it, some of us in long flowing beards. But with the coming of the motor car the chimney pots vanished and the long tailed coats, while bowlers and soft hats and sac suits became the fashion and more or less clean-shaven faces. Now a doctor in a frock coat and bell-topper driving in a motor car would seem prehistoric.

Medical Schools.—There was no medical school in South Australia, nor until 15 years afterwards. The ranks of the profession were recruited from abroad. Not until 20 years later was the first State-educated medical man granted his University degree as a qualification for practice. Now we can supply more than a dozen medical men a year and will probably be able to educate as many as we need, and yet our supply is not at all likely to exceed our demand for many years to come, for population must increase in so healthy and delectable a land.

British Medical Association.—The British Medical Association had no Branch here. A South Australian Medical Association existed, but was almost wholly ethical in its function, established with a view to maintain the respectability of the profession, and to protect it against what were regarded as abuses. What an influence has our Branch exerted upon us! not only in maintaining our *esprit de corps,* not only in bringing us together, letting us know one another's good qualities, and so ensuring our good fellowship and harmony, in diffusing and improving our theoretic and practical knowledge, and so making us more capable as well as happier men. Out of this has grown our Federal Committee, the means of direct communication with our Federal Government, and the collector of our consensus of opinion on questions of internal administration and external relations.

Australasian Medical Congress.—Intercolonial Medical Congresses were unknown for nearly twenty years. Then came "the flash of genius" from Dr. Poulton, and they have been held regularly ever since, till the interruption of the war. They have grown in favour, in interest, in importance and in power,

[1] Delivered at the Annual Meeting of the South Australian Branch of the British Medical Association on June 26, 1919.

and will continue we trust to exercise a beneficent influence over the profession of Australasia, similar to what the British Medical Association Branches have over us in each State. Acquiring momentum and securing the public confidence as the years roll by, may our Congress be recognized by the people of the Commonwealth as an organization which is not only the mouthpiece of our matured conviction and common sense, but a benevolent adviser as to their common well-being and welfare.

Trained Nurses.—Nursing was in its infancy. The complete absence of trained nurses in such a hospital as St. Bartholomew's can scarcely be credited to-day. The authorities were just making preparations to build a nurses' home close to the Little Britain Gate when I left in 1878. Some of the Sisters in charge were trained nurses, but others even of these had gleaned all they knew by their own observation in the wards. A legend floated about "St. Bart.'s" of the engagement of "Old Sister Mark." A nurse was wanted, so applications were invited. The hospital steward, old Mark Morris, was doing some repairs to a faradic battery when she came to his office; he asked: "Well, what do you want?" "I'm come about the nurse's place!" "Oh, are you? Well, catch hold of these," and he put the electrodes one in each of her outstretched hands and turned on the current. They shivered and jerked, but she kept her hold and held her tongue. He judged she had a will and a nerve of her own, smiled his satisfaction and said: "You'll do," and sent her into the Hospital, where she remained for untold years.

Imagine the capital of South Australia without one certificated nurse in the hospital or in private, medical, surgical or maternity. Midwifery was done in the homes of the people. I cannot remember attending a case in a private hospital until about 1890. The obstetric nurses were mostly middle aged women who had picked up their knowledge by experience without any special training. Most of our surgical operations were performed in the patient's house; we drained empyemata, tapped hydatids, opened abscesses of the liver, treated broken limbs, removed ovarian tumours and, in fact, did whatever arose. There were no private hospitals in the present sense of the term, although there were some houses to which people could go to be confined, or in which they could live when ill. Now we have certificated nurses in abundance, fully trained in all departments of medical, surgical and maternity work, for the assistance of the profession and the advantage of the suffering.

Specialism.—There was not a specialist in the profession, not one! A few men had a limited reputation in particular departments. Dr. Wylde was supposed to be very good in eye complaints, and one or two other doctors had lotions called by their names; but there were no experts or specialists. Even at the Adelaide Hospital on my appointment to the honorary staff in 1882, medical and surgical cases of all kinds were placed in the same ward without the slightest discrimination, except that males and females were in separate rooms. Broken bones, pneumonias, wounds and bruises and putrefying sores, typhoids, hip diseases, bad eyes and everything else as they happened to come in were put into the bed which chanced to be vacant, and the general practitioner went from one to the other and treated them all as he passed along. Now we have appropriate distinctions, physicians, surgeons, gynæcologists, ophthalmologists, otologists, dermatologists and radiologists. This is a great advance and has been of benefit to doctors and patients alike. Would not an extension of this principle be of still further advantage, *e.g.*, if in private practice as well as at the hospital the distinction were maintained, and certain of our rising practitioners would determine to be pure physicians and pure surgeons, not only in name but in fact? And even further, if among these some would seek to become pre-eminent in one class of complaints, and others in another, so as to be recognized experts in them; such as heart, lung, kidney disease, without abandoning altogether their hold on general medical practice? Certain sections of medicine are becoming so extensive and elaborate as to render it difficult for even a pure physician to keep pace with the literature of them all, and it would be of benefit to both profession and patient if a subdivision of labour were effected. At the present time, diseases of the nervous system particularly call for this. Their diagnosis offers special difficulty. It requires more material for observation than falls to any one physician in Adelaide even though he be an honorary at the Hospital, and it demands more time and patience than any honorary under present circumstances can afford. If a physician could be found ready to take up neurology as a specialty and a certain number of beds could be set apart on the male and the female side for him, and his work in the institution were limited to these, he could concentrate his attention upon this group of diseases and make himself perfectly acquainted with all available literature relating to them. He would give himself with patience and industry to their examination. He would become expert in their investigation; this would then be relatively easy to him. He would acquire a rapidity and assurance in framing a diagnosis not possible to the man who, though he has abandoned surgery, still devotes himself to the whole field of medicine. Nervous diseases too are of late coming much more under the control of remedial measures. "Hysteric" troubles are being divided up, and the pithiatic group when surely recognized, surely and quickly respond to suggestive treatment. Even organic troubles (or what were regarded as wholly organic) are found to be only partly structural and largely functional, and hence in great measure responsive to re-education. Moreover, not a few wholly organic lesions are now curable by surgical means, provided these are employed at an early stage, such as tumours of the cord, hydatid and abscess of the brain, etc.. Diagnosis, therefore, becomes of increasing value, especially early and certain diagnosis. Unless it is fairly certain, operation will be deferred because so often difficult and dangerous, and if delayed, it becomes not only more dangerous but less effective. Hence the special need of an expert who can be relied on and who has confidence in his own ability to frame a definite and exact pathological and regional diagnosis and so make early operation not only justifiable but advisable and even imperative.

The sphere of neurology may to some seem too restricted to engage the whole energy and ambition of a man. But why? What comparison is there between ophthalmology or dermatology and neurology, between the eye or the skin and the whole nervous system, brain, cord and nerve of every name and kind? More, it is a realm where untold possibilities lie, and where unthought-of discoveries are awaiting the explorer, where a name is to be won, and where such help is to be given our brother practitioners as will compel their regard and support, and such benefit to be conferred upon our fellow-men as will win their golden opinions as well as their golden guineas. Were I twenty or thirty years younger I should plead for a neurological department in the Hospital and be ready to take charge of it, in-patient and out-patient too, if necessary, and become a neurological specialist. It would need a clear head, close study and careful, patient, thorough application to clinical observation, but it would be a compact department with very few competitors, with abundant scope for research and a wide field for beneficence.

New Symptoms.—In those early days we had no use for the knee jerk, or ankle jerk, or any other jerk, for clonus of any sort, for extensor or flexor, plantar or other cutaneous reflex. We knew when boys at school, that if we suddenly chopped a fellow below the knee-cap, his leg would jerk forward and that if, while sitting, we rested the ball of our foot upon the floor in a particular way our leg would rhythmically move as long as we liked, but the greatest neurologist in London in 1870 had no more knowledge of their diagnostic value than the schoolboy. We were not even aware of the Argyll-Robertson pupil and so knew nothing of its relation to *tabes dorsalis*, or general paralysis of the insane, or that it was pathognomonic of syphilis. The tracheal tug was unheard of and so one of the best evidences, sometimes almost our only one, of aneurysm of the aortic arch was wanting. And so with many others, perhaps less well known, which time would fail me to enumerate.

Antisepsis and Asepsis.—Though Lister as early as 1867 was elaborating his method of antiseptic treatment of wounds, it was in 1869 (just 50 years ago), when elected Professor of Clinical Surgery in Edinburgh, he delivered his introductory lecture and brought it forward with special prominence. London regarded it with indifference, or treated it with scarcely concealed contempt. Moving thither as Professor of Surgery in King's College, Lister practised his system in its Hospital, but as late even as 1879 Savory, Lecturer on Surgery at St. Bartholomew's Hospital, attacked it and its author in an annual opening address. So that during my term of nearly seven years at that hospital, from 1870 to 1877, its surgery was carried on almost wholly under pre-antiseptic conditions. George Callender, with whom I dressed, and Tom Smith, for whom I acted as house surgeon in his ovariotomy cases, were two of its surgeons who as exceptions came to some extent under Lister's beneficent influence, with a consequently reduced death-rate in their operations. In the earlier years no attempt was made to prevent infection of wounds. No gowns or masks were worn. Each surgeon had his operating coat hanging on a peg against the wall in the operating theatre. It was an old broadcloth frock coat. He took off his clean coat, to prevent it from being soiled with spurting blood or pus, and put on his operating coat, which was stiff with clotted gore and coagulated secretions of various kinds—the more soiled and stiff, the more he gloried in it, as the proof of his prowess in many a bloody operating field. He turned up his shirt cuffs, put on this ancient frock coat, buttoned it up to his chin to protect his shirt front and then waded in, with a brother surgeon similarly attired to assist. When the limb had been amputated the vessels were picked up with forceps and tied with unsterilized silk. The ligatures were not cut off short, or rather only one thread was; the other was left long enough to be brought out of the wound. On the face of the flaps of an operation through the thigh there would be a score or more of these ligatures, which were gathered into sheaves and brought out at the nearest point. Of course suppuration was inevitable all along their tracks; as the days passed by, each of these ligatures was given a little tug to discover whether the vessel had ulcerated through at the point ligatured and freed the thread, and when the last was tugged away, which was sometimes not for a fortnight, the healing could take place. We watched for secondary hæmorrhage at the time of their separation, and were very gratified if it did not take place.

Ovarian tumours were removed, because if left alone the patient died; and they were removed unwillingly, because if taken away the patient usually died the sooner. The cause of death was generally septic peritonitis. The pedicle was brought out of the abdominal cavity and held there by a steel clamp or by a *serre-nœud*, an iron wire made tight by an apparatus like a small *écraseur*. The tumour was cut off distally to this, and the stump was dressed once or twice daily until it had withered or putrefied and the clamp or *serre-nœud* would come away. One element of danger was the infection of the abdominal cavity by septic fluid from the sloughing stump, and another was the drag upon the broad ligament by the clamp outside the abdomen, especially in an obese woman, or when the belly began to distend with flatus. Later the extra-peritoneal treatment of the pedicle was abandoned, and the stump ligatured with silk was left inside. This was a gratifying advance, but only became possible when ligatures were sterilized. As for uterine fibroids these were dealt with in a similar manner, but their ablation was much more difficult and dangerous, first because the present rational manner of securing the uterine arteries had not been introduced, and the bleeding was often furious, even uncontrollable, and secondly because the pedicle consisting of the neck or even the body of the uterus was massive and deep-seated, and took so long a time to ulcerate through. When the fibroid was intramural, or involved practically the entire womb, the patient had a better chance of life if left alone. But the whole technique of myomectomy and hysterectomy has been gradually elaborated, until now it is quite a safe and absolutely curative procedure. How great the advance is manifest to a practitioner who in the

early days has had to watch a patient slowly die of progressive secondary anæmia from hæmorrhage due to inoperable fibroids, or to see her die after a few days or on the table before the conclusion of the operation. Students of to-day can have no adequate conception of what Listerism has done for humanity. In the olden time a case of epithelioma of the lip with enlarged glands below the jaw, was left alone, and so was cancer of the breast with definite hardness of the axillary glands. These were infected and, if unremoved, would make the primary operation useless, whereas if the submaxillary or axillary planes were opened up and the glands taken out, the patient would as likely as not die of diffuse septic cellulitis. Now how different, the primary growth is taken away with as much surrounding tissue as may be involved or as can be spared, and all its lymphatics up to and as far beyond the infected glands as possible are removed, and the whole area can be expected to close up by primary adhesion.

In those pre-aseptic days two terms were used we scarcely ever hear to-day in reference to the healing of wounds. The first was "by first intention" and the other "by second intention." Later they were styled "primary adhesion" and "granulation." If we sewed up an open wound we hoped the two edges would unite at once without any discharge; and if they did, which was seldom, we congratulated ourselves on an instance of healing by "first intention"; if it opened up in part or all of its length and discharged pus we were scarcely disappointed, it would heal up more slowly by "second intention" or "granulation." Of course, whenever a vessel was tied, there must be suppuration and granulation along the track of the ligature. To obviate this some surgeons, Callender especially, avoided ligatures as much as possible and twisted every vessel with a pair of forceps; and I have known him twist the femoral in an amputation of the thigh and trust to this to control of hæmorrhage, which was certainly taking a great risk. We had a special instrument, the artery torsion forceps, to effect the process. Twisting is still done, but only, I think, in the case of very tiny vessels.

One remembers, too, when antiseptic surgery was at its height and a spray of carbolic acid from a special engine was kept playing over the patient, until the whole room was filled with mist, maintained from the moment of operation until the dressing had been applied. And one recalls the advance, the momentous advance, when antisepsis gave way to asepsis, when irritating chemicals were replaced by boiled water, clean hands, clean instruments and clean garments; when sponges which were scarcely capable of complete cleansing, were discarded in favour of sterilized gauze and all effort was concentrated on having everything biologically clean, and this is the ideal point at which we have now arrived. "Perfect," dare I say? Should I not rather add "for the present"?

New Operations.—How many affections then regarded as medical have been transferred to the surgeon. Gall-stones, for instance, could only be treated by drugs given for relief of pain. I quote a text-book: we could "neither dissolve them, nor remove them, nor prevent them from growing larger." Now we can not only take them from the gall-bladder when they are present in thousands and so prevent thousands of attacks of biliary colic, but from the common duct and so cure a persistent or intermittent obstruction, which, left alone, resulted in a lingering and often miserable illness from gradual marasmus, attended by an intolerable itching, which nothing could cure and scarcely mitigate. So with appendicitis; in those days we recognized "typhlitis," an inflammation of the caecum; "perityphlitis," an inflammation of the tissues around the caecum, and "appendicitis," an inflammation of the appendix. Various causes were enumerated, but the appendix was not specially incriminated. Patients were treated medically with foments, leeches or ice locally; and should an abscess form, by aspiration or lancing; and as "recurrences were not uncommon, they were to be avoided by special care as regards diet, cold and other injurious causes." No suggestion was made as to the desirability of an operation for removal of the appendix, for the simple reason that its causative relation to the trouble was not recognized. Removal of the caecum in typhlitis would have seemed just as rational. Besides, to open the peritoneum and perform an operation within its cavity involved, through septic peritonitis, as much danger, if not more, than expectant treatment. Now through the work of Treves, the appendix is known to be in the vast majority of cases the *fons et origo mali,* and its ablation is the shortest and surest road to recovery. To-day the abdomen is opened to certify an uncertain diagnosis in intra-abdominal troubles and to determine whether an operation for relief or cure is possible. Fifty years ago the proceeding would have been disastrous and regarded as homicidal. Think of all the new operations for surgical relief in gastric and intestinal troubles, in renal and vesical diseases, in cerebral, spinal and nerve complaints, in gynæcological conditions and in orthopædic and plastic work. The realm of medicine has experienced a revolution and radical surgery is in the ascendant. I remember well the time when the operation for naso-pharyngeal adenoids was introduced. These growths were unknown to me as a student. A foreign medico recognized them, investigated them, worked out their treatment and launched the subject upon the profession practically in the same form as it is dealt with to-day. I recollect my first case. I gave the ether and W. Anstey Giles operated in the hanging head position, and the loss of blood nearly took my breath away. Imagine the state of the child-world in the days when all mouth-breathers went through life with their adenoids untreated.

X-Rays.—There came a time when, according to conjecture, surgery had attained its limit. The X-ray was discovered, which could traverse solid tissues and reveal their comparative opacity. and immediately a new field for surgery was opened up, with a certainty of presence, an accuracy of location and a determination of nature before unknown, and the field and frequency of surgery were at once increased; and now the screen and the skiagraph make sure what before was so questionable as to discourage interference. And not only is the X-ray a wonderful aid to diagnosis, but it is also no less a therapeutic in preventing the recurrence of cancerous growths,

in the cure of parasitic skin disease and of serious diseases of the blood and of endocrine glands. All this has germinated, grown, developed and fructified within our professional life-time. And here we may refer in passing to the discovery and use as a therapeutic agent of the marvellous material, radium, so closely allied to X-rays in nature and in action.

Disease Germs.—We knew absolutely nothing when I began my medical education of the germs of infectious fevers. Just before leaving the Old Country, a germ theory as a possible explanation was under discussion, and Maclagan was its energetic exponent. Its fascination is a pleasant memory, with its postulated different species of germs, probably animal, which gained entry into the system, fed each one upon its special pabulum, multiplied at the expense of particular tissues, induced its fever by the greatly increased metabolism associated with its excessively active growth and multiplication, died out when all its food had been consumed and by such consumption gave a lasting immunity, since no more of this pabulum remained for any identical germ to feed upon. The theory was crude and simple; there were no antigens or antibodies, toxins or antitoxins; these were undreamed of, but it was none the less attractive as a working hypothesis.

The only germ we knew was the *Spirilla obermeyeri* of relapsing fever, which its discoverer did not feel justified in revealing publicly till 1873, five years after he first discovered it. It was certainly a most impressive germ, given as a wood-cut in the *Lancet*, in the shape of a corkscrew and not at all an ideal conception of an infectious fever agent. It was not until ten years later, thirteen years after my medical studies began, that Koch recognized the bacillus of phthisis and proved it to be the cause of tuberculosis, and so gave us an infallible diagnostic, one which the microscope made absolute, in place of our previous probable determinations from clinical data. Since then the secret of their causal organisms has been wrung from one complaint after another. The bacillus of typhoid fever, though seen by Eberth in 1880, was not grown in pure culture till 1884 by Gaffky. In the same year Loeffler isolated and cultivated Klebs' bacillus of diphtheria and Fränkel discovered the *Diplococcus pneumoniæ*. In 1885 the *Bacillus tetani* was found by Nicolaier, and much later Kitasato made pure cultures of it and certified its causative relationship with lockjaw. The gonococcus, though described in 1879, and associated with venereal disease, was not grown until 1885 by Bumm, who thus proved the association to be causal. And only as recently as 1905 was the *Treponema pallidum* of Schaudinn and Hoffmann tracked down and determined to be the agent responsible for the Hunterian chancre and all the woes of syphilis. We need not enumerate all the infections which have during the past half century been traced to their ultimate source, but let us look for a moment or two at the significance and the gain of the knowledge acquired.

Definition of Disease.—How much more surely defined has disease become! The Klebs-Loeffler bacillus has shown us the identity which was so long questioned of croupous laryngitis and faucial diphtheria, as well as the diphtheritic nature of some forms of purulent rhinitis and otitis and has enabled us to say these sore throats are diphtheritic and those are not, while the presence of the *Treponema pallidum* has shown immediately on laboratory examination a markedly diphtheroid throat to be really a primary syphilitic sore.

The pneumococcus has proved lobar pneumonia, primary empyema, some cases of purulent arthritis and abscesses, inflammations of other serous sacs and even of mucous membranes to be all manifestations of the same complaint. Abscesses may be typhoidal, as may cholecystitis and even non-septic bacilluria.

The young practitioner of to-day, with a government laboratory at hand and a trained bacteriologist to examine blood, cerebro-spinal fluid, pus, urine and swabs, can scarcely imagine the anxiety of the olden time in the diagnosis of infectious disease. This was sought in an accurate history and a very close observation of all available signs and symptoms, and while it tended to develope patient, exhaustive and careful investigation and so to produce capable diagnosticians, it necessarily left much to be desired as regards absolute certainty; often this was impossible and worry was inevitable. In those olden times Murchison wrote a great book on "Continued Fevers," regarded as a classic. He was one of my examiners for the London M.D., so I knew his book well. He called typhoid "pythogenic fever," "begotten of filth," and thought it could be spontaneously generated by putrefying organic matter, apart altogether from any specific poison; but Eberth's bacillus has dissipated this mistake, and we can quote with assurance the dictum "No Eberth's bacillus, no enteric," however much filth; and how nasty soever the smell, no spontaneous generation. But given the bacillus in milk, in water, in food, even in oysters, however seemingly pure they may be, danger is there, disease is immanent and contagion is imminent.

Diagnosis by Germ Products.—As a corollary we have those bio-chemical and pathological examinations of the body fluids which are of such inestimable value in the diagnosis of cryptic complaints.

Think, for instance, of the "compluetic" reaction, usually known as the Wassermann, as a crucial test for syphilis. We find some strange mental failure in a patient, who gives a perfectly clean social history and not a solitary objective sign, except a somewhat contracted pupil in one eye, which also has an Argyll-Robertson pupillary reaction. What shall we do? Blast his character and our forecast with a diagnosis of syphilis? Who would dare to do it? Make a blood test, the reaction is positive and the diagnosis is sure.

And so also with enteric fever and the Widal agglutination test. In olden time we made our diagnosis by a process of exclusion and by the presence of certain symptoms, if they occurred; but it was often long delayed and dubious, but now a positive Widal makes us positive. And should it be negative we can resort to paratyphoid A or B, and prove perhaps our quasi-typhoid to be one or other of these very similar maladies.

Treatment by Germ Products.—As a further corol-

lary to the discovery of the bacilli has come the manufacture of their cultivation products, *in vitro, et in corpore vili*—in culture media and the blood of animals—and so we have our antitoxins of diphtheria and tetanus and our simple or polyvalent vaccines. Among the latter we find our prophylactic means for typhoid, tetanus and, dare I say, our influenza preventives; and among the former our marvellous curative measures, as, for instance, in diphtheria, the mortality of which has been so satisfactorily reduced, as well as its severity and extent, so that the debated question of tracheotomy, as well as its necessity, has nearly disappeared, resulting in a greatly lessened solicitude on the part both of the physician and of the surgeon.

Prevention.—And as a final corollary we have preventive medicine, with its possible, if not its full, efficiency. We know the ultimate causes of disease—these living organisms—and we can prevent it, by excluding them, or by destroying them. In practice, through fear of infringing personal liberty, through penury or parsimony (a penny wise and pound foolish policy), which grudges the wherewithal to control infection, or through carelessness, which only perfunctorily or in pretence carries out the thorough arrangements demanded by science, infections still occur, and some are still rampant. Nevertheless, preventive medicine, by virtue of its knowledge of germs, has achieved marked success against many diseases, well nigh eliminated some of the former scourges of mankind and made the world a healthier place. And as those in authority come to perceive the invaluable possibilities of preventive medicine, the silliness of a sentimental but selfish so-called liberty and the necessity of indefatigable thoroughness in the hunting of the elusive microbe and (shall we say?) when as a consequence of this they establish a Ministry of Health, whose duty it shall be to insist on *bona fide* preventive measures, other of our demoralizing, dementing, deforming, disfiguring, disgusting and destroying affections shall be swept away, the population be incalculably increased and the individual live longer, be stronger and have a happier life.

Blood Parasites.—The whole story, too, of hæmozoic parasites has been written. In 1872 Lewis first found the *Microfilaria nocturna* in human blood, and to it he attributed the chyluria of the tropics; though as late as 1876 Bristowe regarded its presence as not causal, but only fortuitous. Thirteen years later the parent worm, *Filaria bancrofti* of Cobbold, was discovered by Bancroft of Brisbane. The peculiar periodicity observed by this parasite, which appears in the peripheral blood stream at night and disappears during the day, led Manson to think of the Amoy mosquito as the agent of its transmission from man to man and thus the life history of the filaria was worked out and the existence of insect intermediaries in disease was established.

Malaria, with its ague fits every first, second or third day, was an incomprehensible disease; its clock-like periodicity was unaccountable. Its cause was unknown, attributed to "miasm," a sort of marsh mist containing some invisible, intangible, imponderable poison. Its cure was Peruvian bark, whose action was inexplicable. Because it cured these periodic pyrexias of ague, we called it an "antiperiodic" and therefore used it in other periodic pyrexias, such as the hectic of phthisis and pyæmia, quite rationally, but quite ineffectually, for it would not act and why we could not guess. But the plasmodium of malaria was discovered, its life history traced, its transmission by mosquitoes (though only by certain groups) established, the parasiticide action of quinine demonstrated. The miasm has been dissipated, a clear pathology shines forth and, as a consequence, by rational preventive measures, millions of lives are saved and places noted as the cemeteries of our countrymen have been made as healthy as London, the metropolis of the world.

As an extension of the same kind of investigation yellow fever in 1900 was sheeted home to the mosquito and the sleeping sickness to the trypanosome with its host, the tse-tse fly, leprosy to the bug and the plague to the rat flea.

Ductless Glands.—Then, again, the whole subject of endocrinology has been evolved. It began with the thyroid gland really. We knew the cretin, the endemic by repute and the sporadic by experience; but why he was a cretin we could not tell and we could not help him. Many years later we recognized Gull's "cretinoid condition in middle-aged women," afterwards called myxœdema, but we could do them no good. I used to be sorry to see one enter my consulting-room, the case was altogether desperate. Then came the knowledge of thyroid insufficiency, Horsley's implantation of the gland, Murray's hypodermic injection of its extract, ingestion of the glands, lastly the tabloids, and now we cure, not only the marked disease, but a score of affections due to hypothyroidism in varying degree. You cannot imagine the revulsion of feeling begotten by the discovery of thyroid extract. It is worth while to have practised 40 years and to have studied 50 to have seen the results of this one drug, which is far too little used and sometimes employed with insufficient patience and care.

This opened up investigations into the action of a great number of other internal secretions, and the whole field of organotherapy, which has been perhaps more exploited than explored, but which will without doubt yield a rich harvest when fully and scientifically worked, as is being done by some of our most brilliant research physiologists and pharmacologists.

And now what shall I say in conclusion. Is not such a review, though of necessity incomplete and in outline only, sufficient to make one glad his life was given to the science of medicine and the art of healing, that he has been learning this science and practising this art—not like most of the medical men in the middle ages, who spent their days in trying to know what great men had written generations before and to do just the same as they had taught and to whom no fresh beam of light came from one end of their life to the other and who died in the same darkness as their fathers—but who has seen one cloud after another melt from the sky, till it promises to grow brighter and brighter, even to a perfect day. The progress of medicine, and I use this term in its widest sense, gives us ground for highest hope. The advances made during the past 50 years are the

earnest of equal advances during the next half century; but they are more than that; we look forward not merely to an arithmetical but to a geometrical progression. The progress from 1819 to 1869 cannot be compared with that from 1869 to 1919. The discoveries of the last half century altogether eclipse those of the half century before. And so we may anticipate it will continue to be, unless some social cataclysm should plunge the world into confusion. One feels how true a pleasure it would be, with a mind at leisure and alert, to watch the onward march of medical knowledge, see the questions now in dispute settled one after the other, things we do not understand gradually and completely explained and some new power or new law discovered which will open up altogether fresh avenues of investigation and unexpected opportunities of action, just as has transpired during the half century gone by. Perchance it will be granted us. But should it not be, we have this delightful satisfaction, that it will be vouchsafed to you who are just entering upon your inheritance and before whom is opening out a wider and brighter vision than even I have seen. With all my heart I congratulate you and wish you joy of it.

Like one who has received from venerated ancestors a rich inheritance, made ampler through the passing years by gifts from known and unknown friends, fruits of their labour in various fields of science, to be used and enjoyed by me without stint and with a growing sense of pleasure and power to help, I now bequeath this inheritance to others—little or not at all increased, I fear, by exertion or capacity of mine—for their use and enjoyment; with the sincere wish for as keen delight throughout their life as through mine, a delight intensified not only by continual increase in their inheritance, but especially, I trust, by personal contribution, the rich harvest of their own endeavour in some congenial realm of research; and then—a larger bulk and richer store—to be passed on by them with pride as well as pleasure to the next generation of our profession. It has been my privilege in part to prepare many of you for the reception of this bequest. May you find in it a fullness of blessing, flowing from the consciousness of a faithful use of your inheritance and of benefit bestowed upon those for whose welfare it has been entrusted to your stewardship!

Reports of Cases.

INTRAVENOUS MEDICATION IN SPANISH INFLUENZA.

By **Francis Temple Grey, M.B. (Syd.),**
Surgeon Lieutenant, Royal Navy.

Considering the value of antistreptococcal inoculation as a prophylactic against the present scourge, the corresponding serum should be of value therapeutically. I selected for serum therapy six cases at the Exhibition Hospital, Melbourne (five regarded as hopeless and the other on the border line), with the result that two patients, apparently moribund, recovered and the patient on the border line also recovered. The particulars are as under:—

Case I.—T.Y., *æt.* 28 years, a fitter and turner, was inoculated in February, 1919. He was admitted on April 14. His temperature was 39.8° C., pulse-rate 74 and respirations 28. There were no physical signs detected in the chest. On the 17th rhonchi were heard on both sides of the chest in front. On the following day the patient complained of pain in the chest. On the 20th there were rhonchi and friction rubs on the right side of the chest behind and over the upper portion of the left lung. Cheyne-Stokes' breathing developed.

When the patient was seen on April 30, 1919, he was cyanosed; his temperature was 35.5° C. and his pulse was weak. He was given 10 c.cm. of polyvalent anti-streptococcal serum that night. His temperature rose to 38.9° C., but his condition was obviously improved. He slept quietly for the first time; he had been delirious since admission. On May 3, 1919, his temperature was 39.3° C., and fell to normal on the 4th. His recovery from this date was uneventful.

Case II—R.P., *æt.* 18 years, had not been inoculated. He was admitted on April 26, 1919. His temperature was 39.2° C., his pulse-rate 120 and his respirations 28. He had been refused admission at another hospital after lumbar puncture had been performd. Meningeal signs were present. There were no physical signs in the chest. On April 30, there was head retraction and Rodzinski sign on the left side. He was given 10 c.cm. of polyvalent anti-streptococcal serum the same evening. On the following day there was a marked improvement. The patient was rational. His condition became worse on the 2nd and on the 3rd there was marked head retraction. On lumbar puncture clear fluid was obtained. It was not under increased pressure. The patient died on the following day.

Case III.—G.M., *æt.* 28 years, a stevedore, had not been inoculated. He was admitted on April 26, 1919. His temperature was then 39.4° C., his pulse-rate 92 and his respirations 40. There was high pitched tubular breathing over the back of the chest on the left side, with abundant crepitations at both bases. The patient was wildly delirious on the 28th and the 29th. He was given 10 c.cm. of polyvalent anti-streptococcal serum on the evening of April 29, 1919, and was rational on April 30. The dose was repeated that day. His condition was less favourable on May 1, and the dose was again repeated. On May 2, his condition was worse and he died on the same day.

Case IV.—F.R., *æt.* 15 years, was not inoculated. He was admitted on April 24, 1919. His temperature was 39.4° C., his pulse-rate was 120 and his respirations 26. There were no physical signs in the chest. On April 29, there were signs of cerebral irritation. The temperature was 39.4° C., the pulse-rate 96 and the respirations 24. There were no meningeal signs, but there was marked cyanosis. He was given 10 c.cm. of polyvalent anti-streptococcal serum on the night of April 29. On the following day the crouching attitude had disappeared and there was less cyanosis. The dose was repeated that night. He died on May 1. Streptococci were grown in pure culture from the blood before death.

Case V.—W.W., *æt.* 37 years, a clerk, had been inoculated in February. He was admitted on April 27, 1919, with a temperature of 38.2° C., a pulse-rate of 90 and a respiratory-rate of 40. There were crepitations in the right lung behind and rhonchi at the left base. On April 29, 1919, his temperature was 36.3° C.. He was cyanotic and delirious. He was given 10 c.cm. of polyvalent anti-streptococcal serum in the evening of April 29. On the 30th, his temperature was 38.1° C. and the pulse-respiration ratio was 3: 1. There was some improvement that night. The dose was repeated. On May 1 his temperature was 37.2° C. and there was a marked improvement; the pulse-respiration ratio became normal. Recovery from that time was uneventful.

Case VI.—W.A., *æt.* 33 years, a stevedore, had not been inoculated. He was admitted on April 28, 1919, with a temperature of 37.9° C., a pulse-rate of 108 and a respiratory-rate of 32. There were no signs in his chest until May 1, when crepitations and tubular breathing were heard at the base of the left lung and a few high pitched rhonchi at the base of the right lung. On April 30, his temperature was 38.1° C. and there was marked cyanosis and delirium. On the evening of the same day he was given 10 c.cm. of polyvalent anti-streptococcal serum. On the following day his temperature rose to 39.4° C., without obvious improvement in his condition. The dose was repeated in the evening and on May 2 his temperature was 38.3° C., and his condition better. There was less cyanosis and he was rational. On May 3, his temperature was normal. His recovery was uneventful, except for a fugitive serum rash, which appeared on May 8,

I used the polyvalent serum of a well-known American firm, of which such a small supply was available that I decided at the same time to treat six other bad cases (five regarded as hopeless and the other not hopeless) with eusol, with the result that recovery ensued in one of the desperate cases (inoculated in February), and immediate improvement in the hopeful case (not inoculated). None of the other patients treated with eusol had been inoculated.

It would be absurd to generalize from so few cases, but the results are sufficiently encouraging to suggest that serum therapy should be given a further trial. Nor should one wait until the patient's condition is desperate. (1)

(1) Edgeworth, *British Medical Journal*, November 9, 1918.

Reviews.

THE ANATOMY OF NERVES.

The fact that Hughes's "Nerves of the Human Body," a slender book, has reached a second edition is evidence that it is in some demand. Apart from this indication of at least local popularity, there is little in the work itself to merit attention. In its 72 pages there is offered to the reader just such an account of the peripheral nerves as might readily be compiled from an ordinary student's text-book by extracting, and somewhat compressing, the appropriate paragraphs. At its best the book does nothing more for the reader than this; at its worst it falls far behind the better modern text-books in the conveyance of a really intelligent notion of the actual nature of the nerves described.

The standpoint of the book is that of the descriptive anatomist in the narrowest sense of that title, *i.e.*, that of the observer who is solely concerned with the spatial distribution and connexions of certain cord-like or filamentous pieces of dead tissue called nerves. There is rarely a hint of their significance as living organs, save where a connexion with named muscles may convey such information. One notable exception is the addition of a few useful notes on the functional distribution of the sympathetic nerves. Apart from these few notes, however, the account of the sympathetic system might have been written half a century ago. Its essential relations with the cerebro-spinal axis are not explained. The terms "pre-" and "post-ganglionic" do not occur at all; the significance of the white *rami communicantes* and of their presence or absence in different regions is not hinted at, nor is the autonomic character of components of some of the cerebral nerves even referred to. These important matters are not merely part of the equipment of that other water-tight compartment labelled "Physiology," they are also definitely anatomical; they are, in fact, the guiding concepts of the anatomy of the sympathetic system.

In other sections of the book the structural details are often quite unduly meagre. What, for example, is the use of such a description as that given of the olfactory bulb, as "a small oval-shaped mass of grey matter resting upon the upper surface of the cribriform plate"? Yet this is all that the student is told about this portion of the so-called "olfactory nerve," except that the olfactory filaments enter its under surface. It is true that it is figured on plate I. along with the tract and roots. But no inkling whatever of the real anatomical character of any of these structures could be derived from either text or figures. The delineation of the roots, indeed, could only serve to mislead, both as to their structure and their disposition. The same criticism applies to the similarly figured roots appended to the optic tracts on the same plate.

The twelve plates of illustrative drawings are rather more carefully executed than their real character warrants. They are merely diagrammatic, though this is acknowledged only on the cover of the book. They are, however, with few exceptions, quite good diagrams and fully adequate wherever their purpose is merely illustration of the facts of distribution and not the portrayal of actual appearances.

The following instances of erroneous or faulty statement may be noticed. On page 1 it is stated of the olfactory filaments that "these non-medullated fibres, twenty in number, are the axons of the bipolar nerve cells situated in the olfactory mucous membrane." From this the learner might well enough conclude that there were just twenty bipolar nerve cells and twenty nerve fibres in the entire peripheral distribution of the olfactory nerve. On page 2—Optic Chiasma—the commissure of Gudden is stated to be a bundle of fibres in the chiasma "linking up the optic tracts." This is totally misleading, as it is now known that the commissure of Gudden has nothing to do with the true optic tract fibres and probably links up auditory centres in the mid-brain. It is also erroneous, for the same reason, to include the medial geniculate body among the centres of origin of the optic tract. On page 16 in enumerating the terminal nuclei of the vestibular nerve no reference is made to the important descending root and its nucleus.

It is surely time that the caption "deep origin" as applied indiscriminately to motor and sensory cerebral nerves should be given up. In the text on page 5, under this heading, the true origin of the sensory fibres of the trigeminus is nevertheless correctly given as from the cells of the Gasserian ganglion, although this is certainly not a "deep origin." But when we turn to the "deep origins" of the glosso-pharyngeal and vagus nerves we find that these nerves without discrimination between motor and sensory components, are held to "arise" from the dorsal nucleus, the *nucleus ambiguus* and the *tractus solitarius* in the floor of the ventricle. No reference is made here to the true relation of the sensory fibres of these nerves to their ganglia. It is said that the jugular ganglion of the glosso-pharyngeal "involves a few of the fibres of the nerve," and that two ganglia "are formed in connexion with the vagus in the jugular foramen." This mental attitude and these modes of speech betray a conception of the facts of structural arrangement of the peripheral sensory nerves which has become, or ought to have become, obsolete. And this, in the judgement of the reviewer, is characteristic of the book, which is otherwise clearly and well put together.

The preface states that "the old terminology has been adopted through the text." This is by no means invariably the case. The author speaks of medial and lateral plantar nerves in place of internal and external plantar nerves, of thoracic instead of "dorsal" nerves, of *ganglion jugulare* and *ganglion nodosum* of the vagus instead of ganglion of the root and ganglion of the trunk and in the case of other structures medial and lateral are employed in place of the internal and external of the older usage. But in truth the so-called "old terminology" as a consistent system is a myth. There was a chaos of synonyms, and uniformity was only met with within the covers of a single text-book and very often not even there. Many years ago Professor Macalister pointed out that over 14,800 names have been applied to about 7,200 parts! From this ample stock each text-book writer made a selection according to canons of his own choosing. Are we now on the eve of a relapse into the realm of caprice?

[1] Hughes' Nerves of the Human Body, by Chas. R. Whittaker, F.R.C.S., F.R.S.E., etc.. Second Edition, revised and enlarged; 1918. Edinburgh: E. & S. Livingstone. Demy 8vo., pp. 72, illustrated. Price, 3s. 6d. net.

POPULAR OPHTHALMOLOGY.

The enterprising layman, scientifically curious about the diseases of the eye, will find in "Eyes Right,"[1] by Dr. MacPhail, just the thing he wants. In two hours spent in reading 72 pages he can range over the whole gamut of ophthalmology from hypermetropia to sympathetic ophthalmitis. The value of such a book is doubtful, except perhaps to school teachers who are cut off from medical aid, a situation probable enough in India, but, as a rule, unusual. The best chapter is on the hygiene of the eye, where the author insists on good light, large print and fresh air in school buildings. In the treatment of catarrhal conjunctivitis the more heroic measures, such as brushing the lids with 2% silver nitrate solution and washing with perchloride are too freely advocated, as we know that free irrigation with bland saline solution, with sulphate of zinc drops is very often all that is necessary. Based as it is on Fuchs's text-book, the subject matter is quite sound.

[1] Eyes Right: Papers for Teachers and Parents on the Hygiene and Treatment of the Eye, Second Edition, by James M. MacPhail, M.A., M.D.; 1919. Calcutta, London, Winnipeg, Sydney: Butterworth & Company, Limited. Pocket size, pp. 75. Price, 1s. 9d.

The Medical Journal of Australia.

SATURDAY, JULY 19, 1919.

Give! Give! Give!

In 1914 the world was in peril. A power sought to attain supremacy by the exercise of military prowess. A treaty to which this power was a signatory, was regarded as a *bout de papier*. Britain, true to her tradition, entered the arena with little else than a handful of highly trained soldiers, an indomitable courage and a determination to overcome the menacing legions. To the call for help, Australians without any compulsion came forward in their thousands to stand beneath the Empire's unfurled flag. The call included medical practitioners and Australia responded in a magnificent spirit and a loyal adherence to the Crown. Over a third of the medical profession volunteered for service overseas and a large proportion of these men left their wives, families and sources of income to do their duty. Some we mourne to-day; others we welcome back in the hour of peace and victory with an outstretched hand, rejoicing to know that the years of sacrifice have passed them by practically untouched in body and in worldly condition. Others, alas! are impaired physically and will have a hard fight to regain a fraction of their former energy or earning power. Some of the unharmed men will need help to start them again or for the first time on the road. Nor may we forget the widows left ill-provided by the brave dead.

The other two-thirds of the medical profession stayed at home. In very many cases they stayed through no fault of their own. Whether they could have gone or not, the fact remains that they stayed, worked and reaped a harvest, while their comrades were slaving for justice, love of country and duty, on a small pittance. Need it be said that those who remained, have the obligation to see that the returning men are given every chance to regain what they have lost, that the weeping women whose loved ones lie beneath the sod in Gallipoli, France, Belgium or Palestine, do not have their burden enhanced by financial difficulties, that the orphan shall not go hungry and cold? It is the desire of the Federal Committee of the British Medical Association in Australia that the medical officers needing help shall not have to look to the official Department of Repatriation for help. This desire is shared by the majority of the medical practitioners in the Commonwealth. It rests with each member now to insure that this desire shall be gratified.

In another column we reproduce a letter which is being addressed to every medical practitioner in the Commonwealth by the Trustees of the Medical Officers' Relief Fund. It is a direct invitation to those who stayed behind—and also to some returned medical officers who are in a position to help—to contribute "to the utmost of his or her ability." The Trustees hope to collect £50,000 from approximately 2,500 members of the medical profession. Is it excluded that twice that sum may be forthcoming? If we remember that this fund should constitute the first call on our profits and that no other claim can be so near to a medical practitioner's heart as this one, surely an average of £20 per member is a low estimate of our recognition of duty. Duty? Perhaps the word privilege would be better chosen. Give to the widows of our brave dead colleagues who have given their all! Give, not in charity, but in the feeling that you were prevented from serving the Empire, as your dead colleagues did! Give to the man who left his practice and faced dangers and death, trusting to chance to find something left when he returned! Give to the man who will carry with him to his grave grievous marks of the fight for right over might! Give royally!

THE PREVENTION OF DISEASE.

The South Australian Branch of the British Medical Association has elected as its President Sir Joseph Verco for a fifth term of office. In 1915, after an interval of close on 30 years, he was chosen again by his colleagues to direct the fortunes of the Branch during a period of exceptional difficulty. Each year since then he had been solicited to remain in office and he has consented four times, to the great advantage of the

medical profession in the State. This year he was greeted at the Annual Meeting soon after he had received the distinction of knighthood from His Majesty and the congratulations of his colleagues were extended to him while still the occupant of the presidential chair. Sir Joseph Verco is retiring from active practice with a great store of energy which he is expending for the benefit of the profession of which he is an ornament and a leader. His address is singularly apposite. It is a thoughtful retrospect, a summary of the changes which have come over the face of the medical world in half a century. These changes marshalled as they are by Sir Joseph Verco and described with such enthusiasm, appear as inconceivable achievements. Had the problems with which they deal, been treated in the reverse direction, the picture would have appeared far less fascinating. If we regard our small knowledge to-day without reference to the smaller knowledge of by-gone days, we are forced to admit a deplorable ignorance and an unfortunate helplessness in preventing disease and in prolonging life. It is true that the mechanical triumphs of surgery impress the world, but no idealist can be satisfied by a cure effected at the sacrifice of tissues or organs. In one department Sir Joseph Verco admitted that the promise of the future was greater than the achievements of the past. It is in this department that every hygienist strains to make progress and finds the tasks knotty and replete with almost insurmountable difficulties. The department is preventive medicine. In South Australia there is no Ministry of Public Health and the organization set up to safeguard the health of the community is defective. The administration has special problems to overcome in an immense area of land with a small population. The wisdom of granting the local health authorities free play is regarded as extremely doubtful under all conditions, but how much more difficult is it to decide which is the best method of controlling hygienic arrangements locally, when the areas lie far removed from the centres of population and where the inhabitants find the means at their disposal scarcely sufficient to carry out necessary structural and other alterations. Distance again presents a formidable impediment to the aid in diagnosis which the laboratory is capable of affording. Accurate diagnosis must form the basis of all measures of prevention of disease.

South Australia is not alone in the partial failure in this respect. There are many diseases extant in all parts of the Commonwealth, and indeed in all parts of the world, that should not be allowed to exist. The knowledge possessed suffices to eradicate them, provided that this knowledge be properly and uniformly applied. The campaign no doubt costs money, but every pound spent effectively for this purpose means many pounds saved. If preventive medicine is costly, invalidity pensions, the upkeep of public hospitals and the failure of the patients to contribute to their maintenance are ruinously extravagant. But little will be achieved under the present system. It is doubtful whether a Health Ministry is an advance on the old order of things, unless the department can emancipate itself from political control and the administration is guided exclusively by experts who have no need to seek popularity and who are influenced in their actions by scientific arguments and not by the desire to gain votes. The appointment of a medical Minister of Health, as has been effected in Great Britain, may be a solution of the problem. History will decide. We are strongly of opinion that even the most perfect organization of a health department would fail in its aims to stamp out preventible disease unless the co-operation of the whole medical profession is enlisted. Departmental control there must be, but it should be the simplest, the most elastic and the most expert possible. There is no valid argument in support of the present system which admits of six different methods of health administration. If allowance be made for the necessity of a varying administration according to the locality, the problems to be dealt with are the same in every part of the world. It appears to us that it is contrary to economy, to efficiency and to common sense to perpetuate a system of six health departments, or seven, to look after the health of five million people. No true Australian desires to see a lower death-rate in any one State than in the others. The aim should be to reduce the incidence of disease equally in all parts of the Commonwealth. Sir Joseph Verco's demand for a Ministry of Health might be extended considerably further, if we really intend to stamp out diphtheria, enteric fever and other avoidable diseases. There should be one

Ministry of Health for Australia. There should be one efficient health department, planned on the simplest principles and the whole of the medical profession should be required to lend its aid to the department to stifle all sources of infection, as soon as they can be traced and recognized. We trust that some day this suggestion may be put into effect.

BACTERIA IN CANNED FOODS.

The gigantic strides made by the canning industries during the last ten years have only been realized by those who have had an opportunity of becoming acquainted with the statistics of this branch of trade. In the United States of America the annual consumption of canned foods is estimated to-day at 250,000,000 cases. The development of this industry has been mainly accomplished by the method of trial and error employed by those in charge of the manufacturing operations. Although the problem of the preservation of food by treating it is largely a question of sterilization and lies in the domain of the bacteriologist, an exceedingly small part has been played by the scientist in controlling the processes of canning fruits, vegetables, meats, milk and fish. Within recent years the National Canners' Association has instituted a laboratory at Washington where much scientific work has been completed, but the results of these studies are not generally available.

The first published paper on the presence of bacteria in canned foods appeared in 1895. Since this date a considerable body of literature has accumulated relative to the bacteriology of the canning industry. While there is general agreement in the literature that spoiled tins of canned foods contain various kinds of organisms, there is diversity of opinion about the condition of the contents of cans that keep well. Some investigators claim that a certain percentage of these tins, lying around 25%, are not sterile but yield various kinds of aerobic microbes. Others assert that "good" tins are always sterile and that the results of those who hold a contrary opinion, are due to faulty methods of examining tins. Bacteriologists have usually stated that the essential condition to be satisfied in processing canned goods is the production of complete sterilization, while the managers of plants have always thought that the complete expulsion of air from the tins and their contents is necessary if the canned goods are to keep in a wholesome state for some months.

A lengthy investigation[1] on the bacteria present in different classes of canned foods has been undertaken in the Department of Preventive Medicine and Hygiene, Harvard, by Professor J. Weinzirl for the Advisory Committee on the Toxicity of Preserved Foods appointed by the National Research Council. This study was commenced with the object of providing scientific proof of the cause of food poisoning attributed to canned goods. While it is usually assumed that food poisoning can result from the consumption of unwholesome food obtained from tins, there is little proof as to the manner in which the poisoning is brought about. Food poisoning may be due to substances occurring in the food naturally, or to chemical substances added during manufacture, or to products formed by the agency of micro-organisms, or it may follow the ingestion of micro-organisms left in the food by insufficient sterilization or introduced into the tin subsequent to its treatment by heat either through a leaking hole or through exposure of the contents after the tins have been opened. This problem was found to be complex and to depend upon accurate knowledge of the condition of sterilization of commercial canned products. The investigation has, therefore, centred around the presence of bacteria in canned foods.

It would seem from these studies which have been conducted with much care and with many precautions, that commercial canned foods, as found in the markets, are not always sterile. Many classes of goods, selected among vegetables, fruits, milks, meats and fish, have been tested in sufficient numbers to justify a general statement that approximately one quarter of the tins contain viable bacteria. It is noted that some classes of canned products are more readily sterilized than others. In the absence of oxygen these bacteria do not multiply nor induce changes in the contents of the tins. Incubation at 37° C. does not appear to produce any bacterial changes in tins that have been well prepared. It thus appears that the production of a vacuum is an essential condition of the preservation of foods in cans by the methods at present in use.

[1] *Journ. Med. Research*, Vol. XXXIX., p. 349, January, 1919.

A RECORD OF WAR SERVICES.

The Commonwealth Government has determined to compile a list of all Australian citizens who have served or volunteered for service in the war. The list will include those who have left the Commonwealth on active service in the Navy and Army, those who enlisted and were discharged or died before embarkation, those who volunteered but were rejected for physical reasons as well as those who were retained for service at home, those who have served with the Imperial Forces, either by direct enlistment or on engagement by the Commonwealth Government and those who have acted on transports or on merchant vessels operating in European waters. Deserters without any actual fighting service to their credit will not be included in the lists. Honours or distinctions gained on war service will be entered in connexion with the names of the recipients. It is announced that the lists will be issued separately in each of the six Australian States and that in each volume the records of those who have served in the Royal Australian Navy, will be included. A small committee having among its members a Naval Officer, will assist in adjudging the claims of applicants. This committee will receive all applications and determine whether or not the names of the applicants should be included in the lists.

No applications will be needed from those who have served in the Royal Australian Navy, the Australian Imperial Force and the Naval and Military Expeditionary Forces (Tropical Unit). All others coming

under the description given above, are asked to send in their claims for inclusion in the lists to the Acting Adjutant-General of the Military District in which they reside. The claims should be accompanied by evidence of eligibility, such as copies of documents verifying the medical examinations, rejection certificates and the like. It is hoped that the lists will be complete. In order that this may be achieved, those who have a claim, should make an application for inclusion with the least possible delay. The latest date for the reception of applications has not been fixed, but it is tentatively suggested that it will coincide with the return of the last group of members of the Australian Imperial Force to Australia. The volume will be known as "The War Record of the People of Australia."

Members are reminded that they are required to send in their returns under Federal *Income Tax Assessment Act, 1915-1918,* on or before July 31, 1919.

It is with great regret that we have to record the death of Major Richard Horace Gibbs. Major Gibbs, who was the Medical Officer in charge of the Australian General Hospital at Macleod, fell off the platform of a tram as it swung round the curve at St. Kilda and Domain Roads on the evening of July 12, 1919. On arrival at the base Hospital, it was discovered that he had sustained a fracture of his skull. He died in the early hours of July 13, 1919.

Naval and Military.

APPOINTMENTS.

The following appointments, etc., are published in the *Commonwealth of Australia Gazette,* No. 83, of July 3, 1919:—

Australian Imperial Force.

First Military District.

Major (temporary Lieutenant-Colonel) E. Culpin, Australian Army Medical Corps, to be Lieutenant-Colonel. Dated 20th November, 1918.

Major W. G. Forde, Australian Army Medical Corps, having resigned, his appointment in the A.I.F. is terminated. Dated 18th March, 1919.

Third Military District.

Major (temporary Lieutenant-Colonel) H. H. Woollard, Australian Army Medical Corps, to be Lieutenant-Colonel. Dated 20th November, 1918.

Captain W. H. Collins, Australian Army Medical Corps, to be Major. Dated 11th November, 1918.

Fourth Military District.

Lieutenant-Colonel S. R. Burston, D.S.O., Australian Army Medical Corps, to be Assistant Director Medical Services (temporary), A.I.F. Depôts in United Kingdom, and to be temporary Colonel whilst so employed, *vice* Colonel D. M. McWhae, C.M.G., C.B.E.. Dated 7th April, 1919.

Major (temporary Lieutenant-Colonel) J. R. Muirhead, Australian Army Medical Corps, relinquished temporary rank of Lieutenant-Colonel. Dated 25th March, 1919.

Sixth Military District.

Major (temporary Lieutenant-Colonel) C. Mattei, Australian Army Medical Corps, to be Lieutenant-Colonel. Dated 20th November, 1918.

APPOINTMENTS TERMINATED.

Second Military District.

Captain A. P. Murphy. Dated 19th June, 1919.

Captain R. F. Matters. Dated 25th May, 1919.

Third Military District.

Lieutenant-Colonel G. A. W. Knight. Dated 21st April, 1919.

Major W. W. McLaren. Dated 23rd March, 1919.

Major F. A. Gray. Dated 10th June, 1919.

Major R. L. Rosenfield. Dated 20th February, 1919.

Captain P. Shaw. Dated 13th April, 1919.

Captain E. N. Scott. Dated 24th April, 1919.

Captain A. S. Prior. Dated 6th April, 1919.

Captain R. D. Aitchison. Dated 24th May, 1919.

Fourth Military District.

Colonel M. H. Downey, D.S.O.. Dated 27th June, 1919.

Colonel C. T. C. de Crespigny, D.S.O.. Dated 28th May, 1919.

Captain G. L. Bean. Dated 8th July, 1919.

Australian Military Forces.

Second Military District.

Australian Army Medical Corps—

Captain (provisional and temporary) J. G. Edwards to be transferred to the Australian Army Medical Corps Reserve, and to be Honorary Major. Dated 1st July, 1919.

Australian Army Medical Corps Reserve—

Andrew Eric Aspinall to be Honorary Captain. Dated 2nd November, 1915.

Third Military District.

Australian Army Medical Corps—

Captain (provisionally and temporarily) H. S. Forrest to be transferred to the Australian Army Medical Corps Reserve, and to be Honorary Captain. Dated 1st June, 1919.

Australian Army Medical Corps Reserve—

Honorary Captain F. P. Edwards to be granted the temporary rank and pay of Major whilst in charge of the Specialist Ward, No. 11 Australian General Hospital. Dated 1st May, 1919.

Fourth Military District.

Australian Army Medical Corps—

Honorary Captain A. R. Southwood, from the Australian Army Medical Corps Reserve, to be Lieutenant (Honorary Captain). Dated 1st May 1919.

Australian Army Medical Corps Reserve—

The temporary rank of Major granted to Honorary Captain F. J. Chapple is terminated. Dated 21st May, 1919.

Fifth Military District.

Australian Army Medical Corps Reserve—

William Horner Nelson to be Honorary Captain. Dated 28th April, 1919.

GRANT OF HONORARY RANK.

The undermentioned, who has served in the Australian Imperial Force as Commissioned Officer, being appointed to the Reserve of Officers (temporarily) and being granted the honorary rank equivalent to that held by him in the Australian Imperial Force:—

Officer who, on appointment for active service outside Australia, was not serving in the Australian Military Forces.

Second Military District.

To be Honorary Captain—

C. I. Davis. Dated 1st March, 1917.

The undermentioned, who have served in the Australian Imperial Force as commissioned officers, having the rank held by them in the Australian Imperial Force confirmed as Honorary Rank in the Australian Military Forces, as follows:—

Officers who, on appointment for active service outside Australia, were serving and are now serving in the Australian Military Forces.

Second Military District.

To be Honorary Majors—

Honorary Captain E. N. B. Docker, Australian Army Medical Corps Reserve. Dated 1st March, 1916.

Captain W. Vickers, Australian Army Medical Corps. Dated 29th January, 1917.

We are informed that arrangements have been made for the opening of a special department for plastic surgery at the Australian General Hospital at Keswick. Colonel H. S. Newland, D.S.O., is to take charge of this department. Soldiers who have previously been under Colonel Newland's care in England and those who elect to take advantage of his experience in this class of work, may be transferred to South Australia from any part of the Commonwealth for the purpose of attending at the clinic. The cost will be borne by the Department of Defence. Colonel Newland has been in charge of the Australian Section of the Queen's Hospital for Plastic Surgery, Sidcup, for a considerable period.

THE HEALTH OF HOBART.

Dr. Gregory Sprott, the Medical Officer of Health for the City of Hobart, has issued an interesting report covering the year 1918.

Statistical.

The figures given are based on an estimated population of 32,092. The total number of births registered was 1,171, which is equivalent to a birth-rate of 37.58‰ of population. With the exception of the years 1912 and 1914 this is the highest birth-rate for the last twelve years. The lowest rate recorded was in 1908, when it was 25.04, while the average for the 12 years, 1907 to 1918, was 33.04. Since the year 1911 the rate has not fallen below 37. It is interesting to note that the birth-rate for the whole Commonwealth has varied between 26.5 and 28.7 during the same period and that the highest recorded birth-rate for the whole of Tasmania was 30.53.

The number of deaths registered was 378, 203 being of females and 175 of males. The death-rate works out at 11.77‰ of population. Since 1913 there has been a steady decline in the death-rate from 15.55. It was, however, to be noted that in 1909 the death-rate was as low as 9.09 and that it rose steeply and steadily during the following four years. Of the 378 deaths, 76 were of infants under one year of age. The infantile mortality was consequently 63.81 per 1,000 births. This rate has varied very considerably during the past 12 years. In 1907 a rate of 112.7 was registered. In 1909 it fell to 78.42, but rose again in the following year to 113.3. Since that date it has not been above 100, save in the year 1914; it reached the lowest point of 57.72 in 1917. According to the Commonwealth Statistician, the cities with the lowest infantile mortality are Zurich, Rome, Amsterdam, Sydney, Adelaide, Hobart, Brisbane, Perth, Rotterdam, Melbourne and Geneva. Edinburgh, New York, Washington, London, Glasgow, Aberdeen, Liverpool and Birmingham form a group with relatively low infantile mortality rates (between 100 and 120); Milan, Paris, Belfast, Manchester, Hamburg, Munich, Berlin, Chicago, Dublin and Vienna all have high rates, *i.e.*, between 120 and 150, while Marseilles, Brussels, Madrid and Florence have rates between 150 and 200; Montreal and Petrograd have rates over 240, Moscow has a rate of 317 and Bombay of 329.

Early Notification of Births.

The *Notification of Births Act* was adopted by the local authority of Hobart in February, 1918. Under its provisions all births have to be notified to the local authority within 36 hours, stamped postcards being available for the purpose. During the 11 months 1.076 notifications were received. In 309 instances the mothers were usually resident outside the city area. From the notifications it was learnt that 514 of the 1.076 mothers had medical attention, 546 were attended by registered midwives only, while in the remaining 16 cases the patient was attended by a medical practitioner and an unqualified nurse. Rather less than half the births took place in hospitals and maternity homes. Dr. Sprott recognizes that the public are taking advantage of the better conditions offered to the woman during her lying-in period.

Infective Diseases.

The total number of cases of enteric fever notified in Hobart during the year was 29. In two the infection was fatal. Of the 29 patients, 10 came from Queenborough, where no water-borne sewerage system exists, although one has been planned, while the remaining 19 came from sewered portions of the area. The attack rate in the Queenborough area was 25 per 10,000 of population and in the remainder of the city it was 6.7 per 10,000 of population.

There were 65 cases of diphtheria reported, as compared with 109 in 1917. The number of patients admitted to the Infectious Diseases Hospital was 61. There were three deaths. Dr. Sprott endeavours to show the advantage of hospital treatment by working out the mortality rate of two deaths among 61 hospital patients and one death among four patients nursed in their homes. The advantages of hospital treatment, however, are quite obvious. The prevalence of diphtheria has decreased during the past five years, largely as a result of early and complete isolation of patients. No mention is made of any endeavour to trace the source of infection and to render it innocuous.

There were 48 cases of pulmonary and laryngeal tuberculosis notified during the year. In the same period 14 persons died of this scourge. At the end of the year 151 patients were receiving periodical visits. A home has at length been erected for persons with advanced disease. Unfortunately this building is not situated in a convenienet area. Friends have to expend unnecessary time and money to visit the patients. Dr. Sprott fears that reasonable cause of complaint may impel some of the relatives to take the patients home again.

There were two cases of cerebro-spinal meningitis, five of scarlet fever, one of ophthalmia neonatorum, one of poliomyelitis and three of parotitis notified during the year.

Four cases of puerperal septicæmia were reported. Two of the patients died. Full enquiry was made in each case and the midwives in attendance were warned not to undertake any further maternity work until 21 days had elapsed after having ceased to attend the infected patient.

Infective Diseases Hospital, Vaucluse.

During the course of the year 85 patients were admitted into the hospital. Of these, two died. A new nursing home is being erected in connexion with this institution.

General Hygiene.

Of 120 samples of milk analysed, three were found to be adulterated, while two others were just below the required standard. Vendors of these samples were warned, while fines were imposed on two vendors who sold definitely adulterated milk to the public. Dr. Sprott calls attention to the inadequacy of small fines for this offence. We have frequently pointed out in these columns that it is a paying proposition to an unscrupulous milk vendor to sell milk and water as milk and to pay occasional fines when he is found out. The weight of food stuffs seized and destroyed as being unfit for human consumption was 1,625.5 kilograms (1 ton 12 cwts.). This included meat, eggs, cream, fruit, etc.. The fees for inspection amounted to £119.

The remainder of the report is taken up with a short narrative of the work of the medical officer and his inspectors in regard to sanitation, noxious trades, the destruction of rats, the hygiene of factories and analogous matters.

PNEUMONIC INFLUENZA.

Between the dates of July 4 and July 9, 1919, ten proclamations have been issued in New South Wales dealing with pneumonic influenza. These proclamations have been published in the *New South Wales Government Gazette* of July 4, July 8 and July 9. The usual restrictions have been imposed on the community in the Moruya Police District, in the municipality of Cooma, in the shire of Kyogle, in the town of Wee Waa and in the towns of Berridale, Nimmitabel and Coramba. The restrictions previously imposed, have been lifted in the municipal areas of Grenfell, Inverell and Wagga Wagga. The restrictions placed on persons travelling by rail, by road or by sea from Sydney or Mount Victoria or any intervening place for a destination beyond Mount Victoria, or from Sydney or Picton or any intervening place for a destination beyond Picton, or from Sydney or West Maitland or any intervening place for a destination beyond West Maitland, or from Sydney or Dapto or any intervening place for a destination beyond Dapto, have been cancelled.

Abstracts from Current Medical Literature.

SURGERY.

(18) A Bullet in the Precordial Segment of Inferior Vena Cava.

A case of thoracic injury in which X-rays revealed the presence of a mobile bullet behind and to the right of the sternum is described by Duval and Barnsby (*Bull. et Mém. de Soc. de Chirurg.*, July 2, 1918). The position of the bullet underwent a constant variation. Its movement was gyratory and resembled that of an egg dancing on a jet of water. The bullet had entered on the left side. There was a moderate hæmothorax. It was detected later to the right of the sternum. A median vertical incision from the fourth rib to midway between the xiphoid cartilage and the umbilicus was employed with a transverse incision crossing it at the level of the xiphi-sternum. A T-shaped incision through the sternum allowed of a trap-door being lifted up, either towards the left or the right side. The pericardium was opened above, the peritoneum below, and the centre of the diaphragm incised to a proper depth. An excellent exposure was the result, without the pleura being opened. The bullet was located by the radioscope in the upper part of the inferior vena cava. With much difficulty it was worked up to the junction of the vein and auricle. A non-penetrating purse-string suture was inserted at the junction and in its centre a small incision made, the bullet rapidly extracted and the purse-string tightened. At the end of the operation the pulse was 104. Nine days later the pulse was 90 and the general condition was normal.

(19) Pancreatic Lymphangitis.

J. B. Deaver (*Surg., Gynec. and Obstet.*, May, 1919) points out how intimate is the lymphatic connexion between the gall-bladder, bile ducts, pylorus and second part of the duodenum on the one hand and the pancreas on the other. Inflammation of the gall-bladder is followed by enlargement of the cystic lymph glands, periductal lymphangitis and enlargement of the glands at the head and margins of the pancreas. The lymph drainage from the head of the pancreas passes through the lymph glands of the common and hepatic ducts. A cholecystitis causing great enlargement of these glands may thus by pressure produce jaundice. Induration of the head of the pancreas is present in 35% to 40% of all gall-bladder diseases. Deaver believes that the first stage of chronic pancreatitis is disease of the pancreatic lymph glands. The difficulty of diagnosis is great, because the condition is overshadowed by the primary condition of the upper part of the abdomen. Enlargement of the liver has been shown to be frequently associated with disease of the biliary tract. Medicinal treatment in these pancreatic conditions is slow and unreliable, but surgical treatment gives a reasonable prospect of cure.

(20) Secondary Jejunal Ulceration.

Garnett Wright (*Brit. Journ. of Surgery*, January, 1919) reviews the literature of jejunal ulceration following gastro-enterostomy. He follows Paterson's classification into two types: (1) gastro-jejunal, at the line of anastomosis, and (2) true jejunal ulceration some distance away in the efferent jejunal loop. Ætiologically the jejunal ulcer is due to the digestive action of the inactivated gastric secretions on an unaccustomed mucosa. This digestive action is more powerful when hyperacidity is present and when the portion of anastomosed jejunum is far away from the stomach. Local injury predisposes, such as a continuous unabsorbable ligature, a Murphy's button or hard pices of food given too soon after the gastro-enterostomy. Pain is the commonest symptom, but it may bear no relationship to food. Vomiting, hæmatemesis and melæna are rare, local tenderness and a corresponding rigidity common. The preventive treatment consists in the avoidance of sepsis by gastric lavage, etc., careful handling of clamps and the use of absorbable sutures for all layers. An ellipse of mucous membrane should not be excised and the diet for some time should be such as to exclude hard substances. When it has developed, rest with dieting and alkalies should first be tried. If this fails the surgical treatment will depend on the preliminary operation. If an anterior gastro-enterostomy has been performed, it should be undone and the posterior "no loop" method used. Catgut alone as suture material for the anastomosis is an absolute essential at the second operation.

(21) Fracture of the Patellar Border.

Salmond (*Brit. Journ. of Surgery*, January, 1919) calls attention to fissured fractures of the outer border of the patella which are often unrecognized. A history of trauma may be very difficult to obtain, but some slight indirect injury or strain can ultimately be traced. The fissure may be left for right sided or even double. Discomfort and pain are usually felt on the inner side, although without exception it is always the outer border that is involved. The line of fracture is longitudinal or oblique, downwards and outwards, and a linear depression may be felt. Tenderness is present without crepitus and usually there is synovitis. If the condition is recognized early, immobilization in extension with early passive movement and massage is recommended.

(22) To Avoid Colostomy and Colectomy.

In acute obstruction from carcinoma of the caecum or colon, Rendle Short (*Brit. Journ. of Surgery*, January, 1919) seeks to avoid a colostomy by an ileo-sigmoidostomy. The anastomosis is an end-to-side one, the distal cut end of the ileum being brought out of the middle of the wound. Lateral ileo-sigmoidostomy is unsatisfactory, and unless the distal end of the ileum is brought out externally, retrograde peristalsis will fill the colon and caecum with hard scybala. He considers Murphy's button contra-indicated for small intestine work or for large intestine anastomoses, but recommends its use at an ileo-colic junction, as being free from objection. To avoid colectomy in those vague cases grouped under "intestinal stasis," "visceroptosis," etc., he uses the same technique and gives a report of four cases; three of the patients had been relieved of their symptoms and the fourth improved. The diarrhœa which temporarily follows, can be controlled by opium.

(23) Gunshot Wounds of the Chest.

Pierre Duval (*Surg., Gynec. and Obstet.*, January, 1919) describes the method of treating gunshot wounds of the chest, which he has followed since 1916. The operations of urgency are those for serious hæmorrhage and for open thorax. Other indications for early operation are the presence of foreign bodies, unless very small, and the existence of fractured ribs complicating a lung wound. In the latter cases splinters of bone are always carried into the lung. Every wound of the lung showing a large intra-pulmonary hæmatoma by the fluoroscope should be operated on for fear of infection supervening. The favourable time is within 30 hours after the infliction of the wound. The fourth rib in the anterior axillory line is resected for preference. There is less shock than in an abdominal exploration and complete pneumothorax is not associated with any particular danger. A rib spreader is put in and the lung seized in the forceps and examined like the coils of intestine. Bleeding is controlled by ligature, the pleura cleaned carefully with ether and the thoracic wound excised. No drainage is used and the air is aspirated from the pleural cavity after closure.

(24) Metastatic Goître.

A case of thyroid tumour, histologically benign, but causing multiple metastases, is reported by Le Clerc and Masson (*Bull. et Mém. de Soc. de Chirurg.*, December, 1918). The patient, *æt.* 67, complained of "sciatica," and examination revealed a large tumour in the left loin. To remove this, portions of the tenth, eleventh and twelfth ribs were resected and the pleura widely opened. A microscopical report showed the tumour to be formed of thyroid tissue and following this a small swelling was discovered in the left lobe of the thyroid gland, which to the patient's knowledge had existed for some months only. The patient died two months later with symptoms of spinal involvement. The histological examination demonstrated an adenoma of the thyroid gland, intermediate between the fœtal and colloid types. Karyokinetic figures were numerous, and it is suggested that these may be of value as a guide in prognosis.

GYNÆCOLOGY AND OBSTETRICS.

(25) The Operative Treatment of Chorio-Epithelioma.

Vineberg (*Surg. Gynec. and Obstet.*, February, 1919), from an experience of nine cases of chorio-epithelioma and an extensive study of the literature, discusses the clinical side which he states has been more neglected than the pathological. There are two varieties of chorio-epithelioma, one highly malignant, the other semi-benign, but there are no definite histological features distinguishing the one variety from the other. With few exceptions pregnancy has preceded the development of the growth. The ages at which it has occurred have varied from 17 to 55 years. The growth may not appear for many years after the last pregnancy and on the other hand metastatic growths have appeared before the expulsion of a hydatid mole and at the eighth month of pregnancy. In three series of cases quoted the growth has followed hydatid mole in from 35% to 48% of cases, abortion in from 30% to 31%, labour at term in from 21% to 28% and extra-uterine gestation in from 2.5% to 4%. In a series of 200 cases of hydatid mole 5% were followed by chorio-epithelioma. The symptoms are as follows: uterine hæmorrhage may be very profuse and alarming or moderate in amount and protracted, simulating retarded pieces of placenta. Occasionally the uterus may be perforated and profuse intra-peritoneal hæmorrhage occurs, simulating ruptured extra-uterine gestation. Pain usually occurs late when the broad ligaments are involved. Hæmoptysis at times occurs early, due to pulmonary metastasis and may simulate tuberculosis. In many instances characteristic tumours appear in the vaginal walls, usually near the urethral orifice; they are bluish in colour and are very vascular. The uterus is generally enlarged, the cervix may be patulous and admit the finger so that the interior of the uterus may be palpated; if a hard nodule is felt with a distinct excavation in the centre, the diagnosis of chorio-epithelioma can be safely made. Metastasis may occur early or late and in any portion of the body. The most common situation is the lungs and the next the vagina and vulva. The diagnosis is often beset with great difficulties. Chorio-epithelioma should always be suspected when profuse hæmorrhage follows a hydatid mole that has been thoroughly removed. The author recommends a hysterotomy in all cases of hydatid mole, so that the hand can be introduced and all vesicles removed; at the same time, the uterine wall can be palpated for suspicious nodules. Great difficulty occurs when the growth follows an early miscarriage, as the bleeding may be due to retained pieces of placenta. In such cases the pathologist may not be able to help as unless some of the uterine musculature is removed by curette, the microscope may show only normal placental tissue. Curetting is dangerous and especially repeated curetting, as metastases easily occur. In the writer's series of nine cases the only patient who died had been curetted twice. The prognosis varies widely. Early diagnosis without repeated curettings gives a fairly good prognosis. The outcome may be good even with extensive metastasis. Better results have been obtained in cases following hydatid mole, probably because these cases are more carefully watched. The treatment consists in immediate pan-hysterectomy by the abdominal route, unless the growth is discovered when removing a hydatid mole. Wide excision of the parametrium is not indicated, as the lymphatic vessels and glands are seldom involved.

(26) The Results of Procidentia.

Drummond Robinson (*Proc. Royal Soc. Med.*, January, 1919) reports the case of a woman, aged 46, who had complete procidentia after childbirth in 1900. Hysteropexy was performed in 1901. She was confined again in 1902 and the prolapse reappeared. He first saw the patient in 1903. The vagina was completely prolapsed, the sound passed 20 cm., the fundus was attached to the abdominal wall, the supra-vaginal cervix could be felt to be much elongated and very thin. He repaired the perineum, so that a pessary could be worn. Within a year the uterine canal became so shortened that the sound only passed 8.75 cm.. In 1917 he removed the uterus for carcinoma of the cervix; immediately after operation the sound passed 11.25 cm.. This case proves that the elongation of the supra-vaginal cervix may disappear to the extent of 11 cm. in a short time after the uterus is placed in its normal position and shows that the elongation is due to mechanical stretching. Ventrifixation for prolapse without support of the vagina from below is insufficient for the relief of a bad case of prolapse. In the discussion following the paper, Fairbairn said that the specimen and report of the case showed that the common practice of amputating enough of the cervix to bring the uterine canal to somewhere near its normal length was often unnecessary. Williamson stated that there was no doubt about the stretching of the supra-vaginal cervix, as there was usually 2.5 cm. to 3.75 cm. difference in the length of the uterine canal when the organ was prolapsed and when it was replaced in its normal position. In some cases in the later stages the elongation became permanent.

(27) Syphilitic Induration of the Vulva.

Gallagher (*Surg., Gynec. and Obstet.*, May, 1919) in reporting four cases, prefers the term chronic syphilitic induration of the vulva rather than elephantiasis or esthiomene, as they are syphilitic in origin, are chronic in their course and their structure is of an indurative, œdematous type. All of the patients had one or more tumours of the external genitals, which had been growing from one to four years. In one patient there was a cauliflower-like growth of the pernineum and anus and in the others there was ulceraton of those areas. The Wassermann reaction was positive in three of the cases. Histologically all of the tumours were similar. Thickening of the surface épithelium with hypertrophy of the papillæ were the changes in the skin. Beneath were increased fibrous tissue with œdema and enlarged lymph spaces. The blood vessels showed perivascular infiltration. There were giant cells, but no caseous masses. The treatment adopted was the complete removal of the growths with the sliding of skin flaps to cover denuded areas. The condylomatous or ulcerated areas were thoroughly cauterized with the actual cautery. The after treatment was vigorous anti-syphilitic medication.

(28) Labour in a Paraplegic Woman.

Drummond Robinson (*Proc. Royal Soc. Med.*, January, 1919) reports the case of a multipara, aged 31 years, who was admitted to hospital with complete transverse myelitis in the dorsal region of one week's duration. The last menstrual period had ceased six weeks before. She had bed-sores, incontinence of urine and fæces and complete loss of sensation as high as the umbilicus. The uterus increased slowly in size and only reached half way between the umbilicus and ensiform cartilage at full term. The patient said that she felt movements from 5½ months after the cessation of the menses. While the nurse was dressing the bed-sores (281 days from the last period) she noticed a blood-stained vaginal discharge. Strong uterine contractions could be felt about every 2 minutes and 3 hours 40 minutes later a living female child was spontaneously delivered, the patient experiencing only an occasional "niggling" pain. The placenta was spontaneously expelled 25 minutes later. Such cases are rare, only 8 previous ones having been recorded.

(29) Puerperal Anæmia.

H. B. Schmidt (*Surg., Gynec. and Obstet.*, December, 1918) states that occasionally during the puerperium a form of anæmia developes which has not received adequate attention. It is generally called the pernicious anæmia of pregnancy. He gives the histories of four cases. Three patients recovered and the fourth died with metastatic abscesses in the lungs and other viscera. The disease generally starts in the puerperium and not during pregnancy. The blood picture differs from pernicious anæmia in that there are no macrocytes and there is frequently a leucocytosis. From a study of the literature the author considers that infection is the cause of the greater number of cases. Over 70% of the cases were in multiparæ. The symptoms first observed in their order of frequency were pallor, vomiting, diarrhœa and bloating, but always sooner or later asthenia became the chief complaint. The prognosis is bad, as 83% of the patients die. The four cases mentioned were all treated by blood transfusion.

British Medical Association News.

ANNUAL MEETING.

The annual meeting of the South Australian Branch was held at the Lister Hall, Hindmarsh Square, Adelaide, on June 26, 1919, Sir Joseph Verco, the President, in the chair.

Congratulation to the President.

Dr. B. Poulton moved and Dr. H. Swift seconded the following motion:—

> That this meeting has very great pleasure in placing on record its appreciation of the honour conferred on the President by His Majesty the King.

The motion was carried by acclamation, the members rising and giving cheers for Sir Joseph and Lady Verco.

Welcome to Returned Officers.

The President welcomed Dr. T. G. Wilson, Dr. J. S. Verco and Dr. Gilbert Brown on their return from active service with the Australian Imperial Force.

Annual Report.

The President moved the adoption of the annual report. The motion was seconded by Dr. J. E. Good.

Report of Council for Year Ending June 30, 1919.

The Council has the honour to submit the following report for the year ending June 30, 1919:—

Membership.—The roll of 260 members has been increased by the election of fifteen new members, but there have been some transfers to other Branches and some to this Branch from other States.

With deep regret we record the deaths of old and valued members, *viz.*, Drs. T. W. Corbin, W. L. Cleland and Sir Edward Stirling, each of whom was a foundation member and occupied the President's chair and other offices, and whose names will always be associated with the growth and work of the Branch. The late Drs. Niesche and Clive Newland were members for many years and Dr. J. Wells died while on military service. Our most recent loss has been through the death of Dr. A. Campbell Magarey, who, since the bebinning of the war, so ably carried out the duties of Honorary Acting Secretary, except for an interval of eight months, during which he was on active service in Rabaul. There he contracted ill-health, which was probably a contributing cause to his death from pneumonic influenza last month.

Meetings.—There have been twelve Council meetings, and the Branch has met in nine ordinary and two special meetings and one clinical evening. At the special meetings various Federal matters were thoroughly discussed; also the findings of the Melbourne Influenza Conference, at which we were represented. An Advisory Committee on influenza was appointed at the request of our State Government and a new Library agreement has been entered into with the University.

All the meetings have been well attended, especially the more important ones, and ten papers were read and discussed.

General.—The welcome return, after a long period of anxiety, of Colonel Strangman and Major Flood will have given pleasure to our members. Dr. Lendon filled the vacancy on the Council due to the departure of Dr. Smeaton on active service, and Dr. J. B. Gunson temporarily acted as Honorary Secretary during part of the year. The Council conferred with the Editor of *The Medical Journal of Australia* when he passed through Adelaide. The extension of the appointment of Drs. Hayward and Hone as Federal representatives to December 31, 1920, will require the confirmation of the annual meeting. Drs. H. S. Newland and A. M. Cudmore were again re-elected to the Dental Board. The District Medical War Committee has continued its necessary and useful work and still has much before it. The Council has under consideration the following: (*a*) an office for the Branch in the B.M.A. Building and a paid Secretary; (*b*) a new Medical Bill proposed by the Government. Your Council is alive to the importance of this Bill and also to the fact that lodge matters will require consideration by the incoming Council.

The other members of the Council have the greatest pleasure in congratulating our President on the honour of the title recently conferred by His Majesty. We feel sure it will afford satisfaction to the whole of the profession in Australasia and be recognized as a well-deserved reward for work and worth by many even outside our Commonwealth.

JOS. C. VERCO, President.

June 18, 1919.

Dr. H. Swift considered that greater prominence should have been given to the fact that the State Government had consulted the Council in regard to the appointment of an advisory committee to deal with matters connected with influenza. He suggested that the Council might point out the advantages that might accrue if the Branch were more frequently consulted in regard to public health matters. He also referred to the paragraph dealing with the proposal to engage the services of a paid secretary and an office for the Branch. Members were apt to forget that the Hall did not belong to the Branch but to the Medical Hall Company. Only 89 of the 260 members were debenture holders.

The motion for the adoption of the report was carried.

Financial Statement.

Dr. W. A. Verco, the Honorary Treasurer, presented the financial statement and balance sheet (see page 57) and moved their adoption. This was seconded by Dr. B. Poulton and carried, after Dr. H. Swift had called attention to the expenditure of £4 1s. on advertisements announcing the resumption of practice.

Paid Auditor.

Dr. W. A. Verco moved and Dr. J. B. Gunson seconded:—

> That as the finances of the Branch have become extensive, the annual statement of accounts and balance sheet be audited by a certified accountant.

The motion was carried.

Federal Committee.

Dr. W. T. Hayward stated that all matters under the consideration of the Federal Committee had been dealt with at previous meetings of the Branch. He mentioned that at the last meeting of the Council correspondence dealing with postgraduate courses for members returning from active service had been discussed and moved that at the next meeting of the Federal Committee, to be held on July 29, 1919, the following motion should be brought forward by the delegates from their Branch:—

> That the South Australian Branch is of opinion that the Federal Committee at its meeting on July 29, 1919, should
>
> (*i.*) strongly urge upon the Departments of Defence and Repatriation the urgent necessity of post-graduate courses for returning medical officers being provided in the different capitals by one or both of these Departments, and
>
> (*ii.*) should bring before these Departments the injustice already being experienceed by graduates returning to Australia, who have been promised in London that such courses would be established in Australia.

Vote of Thanks to the Council.

Dr. R. H. Pulleine moved and D. A. V. Benson seconded a motion to convey a vote of thanks to the Council and officers of the Branch for having carried out the work during the past year. The motion was carried.

A further vote of thanks was accorded to the British Medical Hall Company for the use of the Lister Hall.

Annual Dinner.

Dr. A. A. Lendon announced that the annual dinner would probably be arranged for an early date. It would be given by the members who had been unable to go on active service to those who had returned.

Election of Office Bearers and Members of Council.

The following were elected office-bearers and members of the Council:—

President: Sir Joseph Verco, Kt..
Vice-Presidents: Drs. H. S. Newland and B. Smeaton.
Honorary Treasurer: Dr. W. A. Verco.
Honorary Secretary: Dr. H. A. Powell, C.M.G..
Members of Council: Dr. E. V. R. Fooks, Dr. J. E. Good,

Revenue Account for Year Ended December 31, 1918.

	£ s. d.	£ s. d.		£ s. d.	£ s. d.
To Sundry Expenses—			By Balance at December 31, 1917 ..		735 4 6
Printing, Stationery, Postage, etc.	27 0 3		„ Subscriptions and Arrears	636 19 9	
Cables and Telegrams	1 6 3		„ Less Amounts Repaid—		
Bank Charge and Exchange ..	0 14 0		Medical Benevolent Fund £17 5 0		
Telephone, 1917 (Balance) ..	1 0 0		Medical Defence Association .. 2 1 0		
Telephone, 1918	2 0 0			19 6 0	
Cheque Book	1 3 6				617 13 9
Advertisements (Resuming Practice)	4 1 0		„ Interest on Treasury Bills and Bank Accounts		20 15 4
Wreaths	2 2 0		„ Subscriptions Received in Advance		15 1 0
Balance of Grant to Federal Committee..	0 10 6				
Salaries Account	67 0 0				
Grant to University Library..	50 0 0				
„ Delegates' Expenses—					
Dr. Hone, 1913-14-15	46 1 0				
Dr. Hayward, 1913-14	39 18 0				
„ *British Medical Journal*	247 5 6				
„ *The Medical Journal of Australia*	223 7 0				
„ Depreciation Written Off	6 13 7				
		720 2 6			
„ Balance		668 12 1			
		£1,388 14 7			£1,388 14 7

Balance Sheet as at December 31, 1918.

Liabilities.	£ s. d.	£ s. d.	*Assets.*	£ s. d.	£ s. d.
To Sundry Creditors—			By Plant—Duplicator, Bookcase, Cabinet		126 19 3
Re Dr. Jay's Advertisement ..	0 9 0		„ Bank Balances—		
The Medical Journal of Australia, 1917	6 10 0		National Bank	118 17 7	
The Medical Journal of Australia, 1918	33 5 0		Savings Bank	236 7 1	
Medical Benevolent Fund ..	0 10 0		Commonwealth Bank	156 18 1	
		40 14 0	„ Savings Bank—Library Fund ..	65 4 1	
„ Balance at December 31, 1918		668 12 1			577 6 10
			„ Petty Cash		5 0 0
		£709 6 1			£709 6 1

May 5, 1919.

Audited and found correct,

H. HIGHAM WIGG.

Dr. A. A. Lendon, Dr. H. H. E. Russell, Dr. F. S. Scott, Dr. Malcolm Scott.

Representatives on Federal Committee: Dr. W. T. Hayward, C.M.G., Dr. F. S. Hone.

Library Committee: The President, the Honorary Secretary, Dr. H. Swift, Dr. A. A. Lendon, Dr. F. S. Hone.

Local Editor: Dr. T. G. Wilson.

Portraits of Past Presidents.

Dr. W. T. Hayward moved and Dr. H. Swift seconded the following:—

That the Council take steps to procure portraits of past Presidents who have passed away, for hanging in the Hall.

The motion was carried.

Roll of Honour.

On the motion of Dr. B. Poulton, seconded by Dr. A. A. Lendon, it was resolved that a Roll of Honour be procured to contain the names of those members who had been on active service. It was also determined on the suggestion of Dr. R. H. Pulleine that an album of portraits of members who had been on active service, or of those who had died on active service, should be procured.

President's Address.

Sir Joseph Verco delivered the Presidential Address (see page 41). Dr. A. A. Lendon, on behalf of the members present, thanked the President for his address. Dr. R. H. Marten supported Dr. Lendon and the vote of thanks was carried with acclamation.

The following have been elected members of the New South Wales Branch:—

Leslie John Shortland, Esq., M.B., Ch.M. (1919, Univ. Sydney), Wagga Wagga, New South Wales.

Alexander Robert Scott-Orr, Esq., M.B., Ch.M. (1919, Univ. Sydney), Fairfield, New South Wales.

Robert Burnside Carter, Esq., M.B. (1914, Univ. Sydney), "Garrawilla," Wahroonga, New South Wales.

Alan Thomas Roberts, Esq., M.B., Ch.M. (1914, Univ. Sydney), Newcastle Hospital, Newcastle.

Henry Joseph Windsor, Esq., M.B., Ch.B. (1909, Univ. Glasg.), has been elected a member of the Queensland Branch.

Cyril Joseph Fallon, Esq., M.B. (1913, Univ. Sydney), Avoca Street, Randwick, has been nominated for membership of the New South Wales Branch.

THE TASMANIAN HOSPITAL BOARDS.

Under the provisions of the *Hospitals Act, 1918*, District Hospital Boards have to be set up in Hobart and Launceston. These boards have now been created, the members being as follows:—

Hobart Public Hospitals District Board.

Government Representatives—

The Honourable W. M. Williams.

C. D. Haywook, Esq.

P. S. Seager, Esq.

R. J. Meagher, Esq.

D. Freeman, Esq.
G. Smith, Esq.
J. R. Johnston, Esq.

Medical Practitioners' Representative—
Dr. James Sprent.

Friendly Societies' Representative—
Edward Verrell, Esq.

Launceston Public Hospitals Board.

Government Representatives—
The Honourable G. T. Collins, C.M.G.
H. Weedon, Esq.
E. H. Panton, Esq.
W. R. Rolph, Esq.
A. T. Marshall, Esq.
W. C. Oldham, Esq.
F. Tyson, Esq.

Medical Practitioners' Representative—
Dr. Gustave Henze Hogg.

Friendly Societies' Representative—
David Storrer, Esq.

Public Health.

VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the four weeks ending June 29, 1919:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total Cs.	Dths.
Enteric Fever	3	0	6	0	9	0
Scarlatina	50	1	69	2	119	3
Diphtheria	227	10	158	5	385	15
Pulmonary Tuberculosis	56	37	26	25	82	62
C'bro-Spinal Miningitis	3	1	0	0	3	1
Puerperal Fever	0	0	1	0	1	0
Influenza	—	189	—	100	—	289

WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the month of June, 1919:—

	Metropolitan. Cases.	Rest of State. Cases.	Total. Cases.
Enteric Fever	15	11	26
Scarlatina	58	26	84
Diphtheria	96	60	156
Pulmonary Tuberculosis	36	9	45
Malaria	51	0	51
Beri-beri	0	4	4
Cerebro-Spinal Meningitis	1	0	1
Erysipelas	1	0	1
Influenza	218	4	222

TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the four weeks ending June 28, 1919:—

Diseases.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Enteric Fever	0	1	9	10
Scarlatina	0	0	1	1
Diphtheria	8	15	74	97
Pulmonary Tuberculosis	3	5	5	13
C'bro-Spinal Meningitis	0	0	2	2
Ophthalmia Neonatorum	1	0	0	1
Puerperal Fever	0	0	1	1

QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the four weeks ending June 28, 1919:—

Diseases.	No. of Cases.
Enteric Fever	17
Scarlatina	31
Diphtheria	185
Pulmonary Tuberculosis	15
Poliomyelitis	5
Erysipelas	7
Anchylostomiasis	2
Puerperal Fever	1
Pneumonia	50
Influenza	13,426
Malaria	4

THE MEDICAL OFFICERS' RELIEF FUND.

The Trustees of the Medical Officers' Relief Fund have addressed a circular letter to the members of the British Medical Association and other legally qualified medical practitioners in Australia. The text of this letter is as follows:—

The necessity for having a fund available for the benefit of Australian medical officers, whose health and interests have suffered through their going abroad on active war service, has been recognized, and the Federal Committee of the British Medical Association in Australia, at its last meeting, drew up the following proposals for the establishment and administration of such a fund, namely:—

(1) That a Federal fund be established by donations from members of the profession in all the States.
(2) That it be vested in Trustees appointed by the Federal Committee.
(3) That a local committee of management be appointed by the Branch Council in each State, to consist of three members of the British Medical Association.
(4) That the fund shall be used in assisting medical officers who have been disabled and the dependants of those who have died.
(5) That the fund shall also be used to issue loans, with or without interest, to medical men who, on account of war service, may require temporary financial assistance.
(6) That to create the fund an effort be made in each State to secure at once as large initial individual donations as possible, or annual contributions.

These proposals have since been adopted, without modification, by all the Branches of the Association in Australia.

In order to facilitate the working of the fund, the three Trustees were selected from one State and the undersigned have been duly appointed by the Federal Committee.

A local committee of management has been appointed in each State. All contributions should be sent to the local committee of the State in which the donor resides. That committee will also investigate all claims arising in its own State, and forward recommendations to the Trustees to be dealt with.

The Trustees, in appealing to the members of the medical profession in Australia for contributions to the fund, desire to impress upon every member the vital importance of this fund to those of our colleagues who have made such great sacrifices in the loss of health and limbs and especially to the dependants of those who have given their lives for their country. They rely upon every individual member of the profession contributing to the utmost of his or her ability.

Although, primarily, the intention was to solicit subscriptions only from those members of the profession who had not been able to offer their services for war purposes, at the request of some returned officers who have served overseas, the Trustees have decided to appeal to all members of the profession, as there are probably

many of the returned men who would not like to be deprived of the privilege of assisting their less fortunate *confrères*.

It has not been possible up to the present to ascertain by actuarial computation what sum is required to meet the necessities of the situation, but figures are available which indicate that, in order to be of substantial value for the purposes for which the fund is intended, a sum of at least £50,000 is required. This sum represents a little less than £20 per member of the Branches of the British Medical Association in Australia and, while some may not be able to give that amount, it is hoped that many others will contribute considerably larger sums. If so desired, contributions may be spread over three years.

The donations as received by the Trustees from the several local committees of management will be announced in the columns of *The Medical Journal of Australia*.

GEORGE ARMSTRONG,
W. H. CRAGO,
GORDON CRAIG,
Trustees.

Obituary.

JOHN FLYNN.

On June 6, 1919, John Flynn succumbed to influenza at his residence in Ipswich, Queensland. He had, in his capacity as Government Medical Officer and in his private practice, many duties to perform that brought him into close contact with patients suffering from the epidemic disease. He was ill for about a week and died of pneumonic complications.

John Flynn was born in Ipswich in 1870. He was the eldest son of Mr. Thomas Flynn, of Woodend, who survives him. He received his school education at Bundanba and later at the Boy's Grammar School at Ipswich. He was a diligent scholar and was leader of the school before he left it in 1888. He then spent a short time at the Melbourne University and before proceeding to Scotland, he employed himself at the Ipswich General Hospital in learning some things about anatomy and dispensing. He worked as a student at Edinburgh and in the year 1893 he obtained the licentiate of the Royal Colleges of Physicians and Surgeons and that of the Faculty of Physicians and Surgeons of Glasgow. Early in 1894 he returned to Queensland and on February 1 of that year he registered his name in the medical register of the State. At first he worked for the Australian Mutual Provident Society and in the course of his duties he saw a great deal of the medical activity in the State. Later he returned to Ipswich and settled in private practice. He soon proved himself an excellent practitioner and within a few years his assistance was sought by a very large number of patients. He was greatly respected and his assiduous care, skill in diagnosis and treatment and kindliness received their reward in the full confidence and warm affection of his many patients. He was a good surgeon and attained a reputation among his colleagues for his neatness in working and preparedness for any emergency. He was justly proud of his results in his thyroidectomy operations. He established a private hospital in Roderick Street, where the greater part of his surgery was carried out. In 1914 he went to Scotland again and there studied for the diploma of Fellow of the Royal College of Surgeons of Edinburgh. He also seized the opportunity of presenting himself for the examination for the degree of doctor of medicine at the University of Durham. This examination is open to practitioners of twenty years' standing without residence. Having obtained the degree he returned to Ipswich and continued his practice. On the death of W. H. von Lossberg, he was appointed Government Medical Officer for Ipswich, a position he held for the remainder of his life.

John Flynn was an excellent son, husband and father. His father, his wife, four sons and one daughter survive him. Two of his sons are studying medicine, one at the University of Sydney and the other at the University of Melbourne. He was a highly cultured man, a devout Roman Catholic and a loyal citizen. His death is mourned by the community of Ipswich and by a large number of his colleagues and friends.

Correspondence.

PROSTITUTION AND VENEREAL DISEASES.

Sir,—A short time ago I was startled to come across the following paragraph, in an otherwise able article on the control of venereal diseases, by Dr. Ellis. "Prostitution has existed from time immemorial, all efforts to abolish it have failed, and therefore it must be accepted as inevitable." I shall be very glad if you will allow me to challenge this statement in your paper by the following questions. (1) In what countries have the proper measures been taken for the control of the feeble-minded, and when? (2) In what places, other than modern European and American States (countries inhabited by coloured races are not, of course, justly comparable to our own), have efforts been made to allow women properly paid work and to educate, or half educate them, and when? (3) In what countries have measures for the proper control and standardization of bad intoxicants ever been taken, and with what results?

It is no exaggeration to say that over 75% of prostitutes are either feeble-minded or high grade morons, etc.. Prostitution, like all other unnatural vice, is chiefly practiced by mental degenerates. For the first time in history, science has made it possible to prevent and to cure venereal disease. The prevention of it may be obtained by the thorough use of prophylaxis, taking say, five minutes before exposure, and the thorough application of early treatment measures as soon as possible after exposure, taking, say, fifteen minutes. To ensure perfection of result, all that is necessary is (1) education on the subject, (2) organization. Therefore, it is possible, for the first time in history, to make prostitution as little likely to breed venereal disease as, say, criminal abortion, masturbation, homosexuality or any of the less popular perversions. What possible excuse, therefore, can remain for urging the Government to make an exception in favour of one unnatural vice, and afford it protection, encouragement and facilities by registering houses for its practice?

When suitable and private provision has been made for the prevention of venereal disease, members of the public who are too dirty or too lazy to avail themselves of these certain preventive measures and who thereby endanger their fellow citizens, should be punished, as other criminally careless persons are at present.

It must be remembered that a registered prostitute, like a registered slave, or a registered abortionist, is a stain on the national honour, and doubly shameful without the excuse of being the only way to prevent venereal disease. I do not attempt to discuss systems of concubinage or polygamy or polyandry, etc., which are, of course, totally different things from registered prostitution, and which may or may not be suitable for some countries, but I do maintain that it is not necessary for the Australian Government to register any of them, or any unnatural vice, and I urge you to use your influence on the side of national honour, especially when there need be no question of national safety involved.

Yours, etc.,

M. S. WALLACE.

C/o. Miss Yencken,
Church of England Home for Children and Babies,
Middle Brighton, Melbourne, Victoria.
July 8, 1919.

Proceedings of the Australian Medical Boards.

NEW SOUTH WALES.

The undermentioned have been registered, under the provisions of the *Medical Act, 1912 and 1915*, as duly qualified medical practitioners:—

Mansfield, Edward, M.B., Bac. Surg., 1914, Univ. Edin.
Messent, Philip Santo, M.B., Bac. Surg., 1918, Univ. Adelaide.
O'Shea, Michael James, Lic. R. Coll. Phys., Edin., 1910; Lic. R. Coll. Surg., Edin., 1910; Lic. R. Fac. Phys. Surg., Glasg., 1910.
Breidahl, Harold George Daniel, M.B., Bac. Surg., 1918, Univ. Melbourne.

Additional Registration:—

Halloran, Garnet Reginald, F.R.C.S., Edin., 1915.

VICTORIA.

The undermentioned have been registered, under the provisions of the *Medical Act, 1915*, as duly qualified medical practitioners:—

McMahon, Leo Luke, M.B. *et* Ch.B., Melb., 1915; 16 Lindsay Avenue, St. Kilda.

Cohen, Bertram Clarence, M.B. *et* Ch.B., Melb., 1918; Melbourne Hospital.

Meade, Warren, M.R.C.S., Eng., L.R.C.P., Lond., 1899; Union Bank, Collins Street, Melbourne.

McNeil, Ian, M.B. *et* Ch.B., Adelaide, 1918; Pinnaroo, South Australia.

Story, Alfred Cuthbert, L.S.A., Lond., 1904; Union Bank, Collins Street, Melbourne.

Shaw, Robert Mervyn, M.B. *et* Ch.B., Melb., 1917; Bank of Australasia, Leongatha.

Lloyd-Jones, John Richard, L.R.C.P. *et* S., Edin., L.F.P.S., Glasg., 1890; 101 Drummond Street, Carlton.

Medical Appointments.

Dr. Annie Lister Bennett (B.M.A.) has been appointed a Public Vaccinator for the Northern District of Victoria.

Dr. A. H. Thwaites (B.M.A.) has been appointed a member of the Committee of the Benalla waterworks Trust. He holds this office for a period of four years from July 6, 1919.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvii.

Herberton District Hospital: Surgeon.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	All Friendly Society Lodges, Institutes, Medical Dispensaries and other Contract Practice. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Australian Natives' Association. Brisbane United Friendly Society Institute. Cloncurry Hospital.
TASMANIA. (Hon. Sec., Macquarie Street, Hobart.)	Medical Officers in all State-aided Hospitals in Tasmania.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA. (Hon. Sec., 6 Bank of New South Wales Chambers, St. George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Australian Natives' Association. Balmain United Friendly Societies' Dispensary. Canterbury United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Friendly Society Lodges at Lithgow. Friendly Society Lodges at Parramatta, Auburn and Lidcombe. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Newcastle Collieries—Killingworth, Seaham Nos. 1 and 2, West Wallsend. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society..
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

July 19.—Northern Suburbs Med. Assoc. (N.S.W.).
July 22.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
July 25.—N.S.W. Branch, B.M.A..
July 25.—Q. Branch, B.M.A., Council.
July 29.—Federal Committee of the British Medical Association in Australia (Melbourne).
July 30.—Vic. Branch, B.M.A., Council.
July 31.—S. Aust. Branch, B.M.A..
Aug. 5.—Tas. Branch, B.M.A., Branch and Council.
Aug. 6.—Vic. Branch, B.M.A..
Aug. 8.—Q. Branch, B.M.A., Council.
Aug. 8.—N.S.W. Branch, B.M.A., Clinical.
Aug. 8.—S. Aust. Branch, B.M.A., Council.
Aug. 12.—N.S.W. Branch, B.M.A., Ethics Committee.
Aug. 13.—North-Eastern Med. Assoc. (N.S.W.).
Aug. 14.—Vic. Branch, B.M.A., Council.
Aug. 15.—Central Southern Med. Assoc. (N.S.W.).
Aug. 19.—Tas. Branch, B.M.A., Branch and Council.
Aug. 19.—N.S.W. Branch, B.M.A., Executive and Finance Committee.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney.